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Supporting Survivors: the Affordable Care Act and Federal Health Policy Addressing Intimate Partner Violence in Community Health Centers

Erin Dunn
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Final Draft

Abstract

How does the Affordable Care Act (2010) address intimate partner violence and its health impacts on survivors? Is there evidence that this legislation positively impacts access to health services for survivors? I seek to compare provisions under the first major piece of federal legislation addressing gender-based violence, the Violence Against Women Act of 1994, to the major policy reforms of the Affordable Care Act. I examine this question through legislative histories of the relevant portions of the Affordable Care Act and the Violence Against Women Act addressing intimate partner violence. In order to examine the Affordable Care Act's impact on survivors' and their health, I will analyze health service mandates, the medical community response, and federal intervention program funding between these two federal acts. In particular, I focus my study on community health centers as sites most responsive to health coverage expansions, providing accessible care to patients most underserved and at the greatest risk for violence. Through this study, I illustrate how the Affordable Care Act's service and funding mandates improve upon prior legislation, and impact access and quality of care for survivors.

Introduction

On average, over 20 people per minute are victims of rape, physical violence, or stalking by an intimate partner in the U.S., yet only 34% of people who are injured by intimate partners receive health care for their injuries (NCADV 2017). There is growing consensus among women's rights activists, public health advocates, and policymakers that intimate partner violence (IPV) is a national crisis of public health, human rights, and sexual and reproductive autonomy. IPV is "one of the most common forms of violence against women, and includes physical, sexual, and emotional abuse and controlling behaviors by an intimate partner" (WHO 2012, 1). IPV is a distinct form of interpersonal violence, characterized by intentional exploitation of intimacy and power in intimate relationships (Mitchell and James 2009). The most prevalent form of IPV consists of male intimate partners or ex-partners exerting violence or coercion against women (Bonomi et al 2007; Mitchell 2009). Intimate partner violence is commonly equated with domestic violence and sexual assault or harassment, and is the most common cause of injury to women in the U.S. (Heron 2009). Mental and physical effects of IPV therefore present a widespread health issue impacting all levels of the health care system, particularly health clinics servicing the most under resourced and at-risk communities.

Yet, despite recognition that IPV is a pervasive issue in the U.S. causing immediate and long-term harm across all regions and demographic groups, a notable lack of policy attention is given to IPV at all levels of government. Through this paper, I am interested in understanding how federal healthcare policy legislation and funding serve to define and address IPV. I specifically examine the most sweeping federal health care reform of recent decades, the Patient Protection and Affordable Care Act (2010) (ACA), in comparison to the first major piece of federal legislation addressing gender-based violence, the Violence Against Women Act of 1994

(VAWA) (Mitchell and James 2009; Runge 2013). While the original 1994 legislation focused almost singularly on a criminal justice response to IPV, its subsequent reauthorizations began to expand protections within a health care framework as well. The ACA signifies the most significant policy reforms, both to the healthcare system in general, and for IPV interventions in the over two decades since VAWA's initial passage (Lizotte 2016; Sonfield and Park 2013).

Through this paper, I aim to fill a gap in existing scholarship by bringing a seminal view through the lens of IPV to evaluate how the ACA changes VAWA, and represents an evolution in federal health policy, in terms of its extension of both mandated services and funding for survivors'¹ services. In particular, I use federally funded community health centers (CHCs) as a case study of sites where the ACA has the potential to be most impactful, reaching the most underserved and at-risk communities. This contributes a new perspective to the literature on health policy and IPV, as little research has yet studied the specific relationship between the ACA and survivors, nor revealed the longer-term impact of the law. I hope that this research will enhance understanding of evolving federal legislation, with the aim of improving future policy-making that prioritizes survivor health.

Furthermore, my driving research question is: how does the ACA address IPV and its health impacts on survivors, particularly within CHCs, and how does this mark a departure from VAWA provisions? The methodology I use to answer this critical question is effectively conducting a legislative history and policy analysis of the ACA through an IPV lens, focusing on 12 key sections of the statute. I trace the formulation and evolution of IPV federal health policy from VAWA 1994 through the ACA. My research design is threefold in that I integrate

¹ I use the term "survivor" to refer to persons who are either currently experiencing IPV, or have been exposed to violence or threats of violence in the past. Discourse and terminology varies by the framework for understanding IPV, with the criminal justice system tending to use the term "victim," while sexual assault and domestic violence advocates prefer the term of "survivor." As this paper seeks to move beyond the criminal justice framework for IPV interventions, focusing on more empowering and health-focused programs, I use the term "survivor" or "patient."

legislative histories, analyses of government reports and secondary data, and funding allocations for comprehensive health services in CHCs.

I illustrate how the Affordable Care Act's service and funding mandates improve upon prior legislation, and impact access and quality of care for survivors. Utilizing legislative and policy analysis, this study concluded that the ACA represents a positive step forward in advancing federal IPV policy beyond VAWA provisions, which were largely limited to a legal and criminal justice response to IPV. My study will prove useful in directing future policy not only in its evaluation of the ACA and how it reforms VAWA provisions, but also in highlighting the degree to which IPV continues to lack sufficient public and policymaker attention even under the ACA, particularly considering its widespread prevalence and magnitude. In this way, my elucidation of areas for improvement under the ACA through service expansions and longer-term program funding guarantees can also inform the development of policy. I conclude by emphasizing the necessity of more accessible, affordable, long-term, comprehensive services and prevention for survivors that go beyond criminal justice and emergency medicine, and funding for these mandates.

This paper is divided into six main sections focusing on the ACA, its policy provisions and funding for IPV, and the potential health impacts for survivors. I begin with a Background section explaining IPV, its occurrence within the U.S., and individual and societal risk factors most associated with victimization. Establishing the magnitude of IPV as a public health problem, and the factors that precipitate this violence, is essential to this paper's study of how the ACA addresses survivor health outcomes through both programs and funding. In the second section, I then discuss the relevant literature by drawing on public health scholars, policymakers, and women's rights advocates in order to contextualize VAWA and the ACA's health policy

provisions. The third section presents my Research Design and Methodology, which includes conducting both legislative histories and policy and funding analyses, primarily through qualitative analysis of bill text and government and secondary reports. In the Data and Results section, I conduct legislative histories of the relevant portions of the VAWA and the ACA, coupled with policy and funding analysis of services for survivors at CHCs under the ACA. Finally, the Discussion section compares changes for health care provisions for survivors between VAWA and the ACA. I conclude my analysis with a summary of my evaluation of the ACA's comprehensiveness and effectiveness in addressing IPV survivor health, as well as present policy recommendations for improving upon existing legislation.

Background

A complete understanding of both IPV, and the ways in which pre-ACA legislation addressed IPV, are essential to contextualize the central questions of this paper and frame my analysis of health policy under the ACA. IPV constitutes a U.S. public health crisis, with profound and detrimental implications for overall mental and physical health, as well as sexual and reproductive health and autonomy. While I discuss IPV's health impacts in greater detail in the Literature Review, it is important to first emphasize the widespread, pervasive nature of violence, as IPV occurs across all settings and among all socioeconomic, religious, and cultural population groups (WHO 2012, 1). IPV encompasses acts of stalking psychological aggression, physical violence or sexual violence, as well as the threats of these acts (Breiding MJ et al 2015). Drawing on the prevailing definitions from the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), an "intimate partner" is a "person to whom someone is currently or has been intimately connected, such as a spouse or domestic partner, a boyfriend or girlfriend, or a dating or ongoing sexual partner" (Breiding MJ et al 2015). This

type of violence can occur among cohabitating or non-cohabitating heterosexual or same-sex couples. In the context of this definition, other forms of family violence, such as childhood sexual abuse and elder abuse, do not fall under the scope of IPV. While each form of family violence is characterized by exploitation of power imbalances within close relationships, IPV is unparalleled in its impact on reproductive health, and is distinct in the romantic or sexual ties defining the intimate relationship. Therefore, forms of family violence beyond this precise explanation of IPV are not addressed within this paper's specific analysis of IPV health policy.

IPV constitutes a form of reproductive control, in which an individual's partner uses intimidation and threats of violence to impose the partner's own intentions upon the individual's sexual autonomy, impeding reproductive choice and health. While the problem of IPV affects people from all types of demographic backgrounds, on both a national and global level this crisis disproportionately impacts women and adolescent girls (Hasstedt and Rowan 2016). Women who experience intersecting inequalities, such as transgender women, LGBTQ women, and women of color, statistically face an even greater risk for IPV and reproductive control, resulting in the dominant framing of IPV as "violence against women" within the public health field.

Violence against women occurs at extremely high rates across the U.S., with estimates reporting that between one in four and one in three women will experience physical or sexual abuse by an intimate partner during her lifetime (Cramer 2004; Mitchell and James 2009). According to leading research and policy organizations surveying sexual and reproductive rights, nearly half of U.S. women experience psychological aggression from an intimate partner, one in four are subjected to "severe" physical violence, and at least one in 10 are raped by an intimate partner over the course of their lifetime. Plus, one-third of murders of women in the U.S. result from violence by a current or former male intimate partner (Hasstedt and Rowan 2016). As a

result of these extremely high incidences of abuse, IPV is the most common cause of injury to women in the U.S. (Heron 2009, 105).

Risk of abuse and victimization are closely tied with specific individual, familial, and societal-level factors that heighten the likelihood of exposure to violence. On an individual patient level, medical providers diagnose IPV as an “actual or threatened physical, sexual, or psychological violence perpetrated by current or former partners” (Pico-Alfonso et al 2006, 600). IPV is associated with several individual risks for victimization, with women who are under 35 years of age, individuals lacking medical insurance, and individuals with partners abusing drugs and alcohol being particularly subject to harm (Heron 2009; Warshaw, Brashler 2009). Within families of origin, IPV is tied to a cycle of violence narrative. Women who are physically or sexually abused as children, or who witness their mothers being abused, face greater risk for victimization in both adolescence and adulthood, as these factors are strongly predictive of future relationship abuse (Warshaw, Brashler, and Gil 2009, 149).

Alcohol and substance abuse are empirically related to elevated rates of both IPV perpetration and victimization, with alcohol dependence correlated to acts of marital aggression (Cunradi 2009, 174). In this sense, specific patterns of heavy drinking and of drug use constitute both causes and consequences of IPV within the context of individuals and couples. It is likely that couples experiencing drinking-related social consequences or alcohol-dependence symptoms have higher levels of marital discord, fights, and verbal aggression, placing the couple at greater risk for IPV. Conversely, recent alcohol-related problems may be indicators of couples whose drinking behaviors and interpersonal relationship have deteriorated from a healthy relationship behavioral status. Cunradi (2009, 177) explicates the involvement of alcohol as having both disinhibiting effect on healthy conflict resolution, and acting as a “discriminative cue” justifying

or excusing violent behavior. Substance abuse, violent behavior, and the overarching public health issue of IPV become inextricably linked in that they historically lack sufficient federal-level allocation of targeted support services, and are important predictors of IPV diagnosis.

Looking beyond such individual and family-level risk factors, populations at the greatest risk for IPV victimization principally stem from communities most lacking in resources and social support services, and most traditionally underserved by health policy and providers. It is therefore critical that this paper examines access to care for survivors in health care settings, particularly looking at changes between VAWA and the ACA, to note policy advancements attempting to alleviate this significant public health strain on vulnerable communities. Risk of IPV is exacerbated by gender and socioeconomic factors, including poverty, homelessness, unsafe living conditions, and physical or financial dependence on caregivers (Warshaw, Brashler, Gil 2009, 151). Inadequate income, lack of available affordable housing, and the vulnerability of women fleeing domestic violence compound problems of IPV by placing women in temporary or unstable living conditions. (Heron 2009, 108). Scholars examining societal factors for victimization routinely point to low socioeconomic status, low insurance status, partner unemployment, low levels of partner education, and poor access to social support services as correlates with experiences of IPV (Cunradi 2009; Heron 2009; Warshaw and Brashler 2009).

Other scholars go beyond history of trauma and individual socioeconomic factors to highlight U.S. societal and cultural factors influencing IPV prevalence. Immigration status is an example of a significant, yet little-studied societal factor for victimization; limited language skills, isolation from contact with family and community, diminished access to jobs, and uncertain legal status exacerbate the immigrant population's victimization rate (Heron 2009,

109). In addition, the feminist perspective informs Cramer (2004) and Runge's (2013) discussions of the evolution of health policy addressing IPV, elucidating the role of institutionalized patriarchal violence and control. Warshaw and Brashler's argument relating to mental health treatment for survivors makes the additional point that "although experiencing or witnessing abuse in childhood may place women at greater risk for being abused as adults, the major risk factor for partner abuse is living in a society that tolerates gender-based violence" (2009, 338). This combination of individual factors, trauma history, and societal and socioeconomic factors are inextricably linked to overall societal health and prosperity. Because IPV has such a far-reaching impact on U.S. individuals, families, and overall societal health and well-being, understanding and addressing IPV within a health care framework is extremely important for examining the ACA and crafting comprehensive federal health policy (Heron 2009, 109).

Literature Review

In order to contextualize both the Violence Against Women Act and the Affordable Care Act's provisions, I begin my analysis by exploring three broader areas of scholarship regarding IPV: (A) medical provider studies detailing IPV and its broad-ranging health impacts; (B) legislative and policy analyses of federal legislation addressing violence against; and (C) public health and advocate best practices for addressing IPV in health provider.

A. Intimate Partner Violence Impact on Survivor Health Outcomes and the Healthcare Industry

Intimate partner violence inflicts significant costs on U.S. societal health and economic productivity. For example, recent estimates of public health costs associated with IPV exceed eight billion dollars annually, including more than one billion dollars associated with life lost (Hasstedt and Rowan 2016; NCADV 2017). IPV places burdens on all levels of the healthcare

system, which is generally ill equipped to deal with the complexity of IPV victimization, or with the added strain of patient volume and resources used. The health care industry is particularly impacted by IPV incidences in that the health arena is an entry point for many survivors of violence to begin to access care. Clinicians and counselors largely serve as this entry point in identifying and treating patients seeking care for IPV-related symptoms, and by providing an opportunity for survivors to report.

IPV survivors experience broad-ranging, and often long-lasting symptoms that can undermine physical, reproductive, psychological, and behavioral health outcomes and overall well-being. Studies conducted by the medical community have largely focused on exploring the relationship between IPV and general health, the types and severity of symptoms, and assessment of symptom-syndromes (Nicolaidis and Leibshultz 2009). IPV is strongly associated with overall inferior general health, as well as wide-ranging physical symptoms that persist beyond immediate or emergent injury caused by physical assault. Women with histories of past physical or sexual IPV victimization exhibit an increased number of chronic and severe physical symptoms, ranging from hearing loss and sexually transmitted infections (STIs) to syndromes such as fibromyalgia, irritable bowel syndrome (IBS), and chronic pelvic pain (Nicolaidis and Leibshultz 2009, 135). These conditions persist even years after the cessation of IPV abuse. Intimate partner sexual abuse presents a related yet distinct problem of IPV, with strong associations between intimate partner sexual abuse and STIs, pelvic inflammatory disease, bladder infections, urinary tract infections, and damage to fertility and the overall reproductive system (Sachs and Gomberg 2009).

IPV compromises healthy reproductive relationships and reproductive health, and poses a heightened risk for pregnant survivors. Beyond domestic violence and sexual violence, IPV

includes forms of reproductive control such as contraceptive sabotage, pressuring a woman to become pregnant against her will, and coercive abortion. IPV is a contributory factor in high-risk sexual behavior, STIs, Human-immunodeficiency virus (HIV), multiple or coerced pregnancies, and pregnancy loss (Bonomi et al 2007; Gee 2012). It is estimated that between 3.9 and 8.3 percent of pregnant women experience IPV, making IPV as prevalent of a health problem as gestational diabetes and preeclampsia (Goodman 2009, 254). The medical community's consensus identifying IPV as a significant problem for pregnant women represents an important step in informing both my analysis of the ACA, and my explication of best practices and future policy recommendations. Pregnancy facilitates a significant increase in the number of interactions between women, their partners, and healthcare providers, resulting in increased opportunities for intervention for women who are experiencing IPV (Goodman 2009, 253). Pregnancy may be the primary opportunity for a health female patient to interact with healthcare providers specializing in reproductive health services (Goodman 2009, 258), creating an opening to discuss a patient's home situation, safety issues, and options to address symptoms.

Physical symptoms are inextricably linked to survivor mental health, with an extremely high co-occurrence of chronic pain and Post-traumatic Stress Disorder (PTSD) (Nicolaidis and Leibshultz 2009, 137; Pico-Alfonso et al 2006). IPV patients consistently present with higher pain intensity, diminished coping skills, and greater physical and psychological disability than patients not experiencing PTSD or IPV trauma. Poor coping skills commonly manifest in additional health problems, eating disorders, and substance abuse, as IPV survivors attempt to escape the effects of abuse and regain a sense of control (Cunradi 2009; Warshaw, Brashler, Gil 2009). Exposure to current or past abuse is a significant factor in both development and exacerbation of psychiatric disorders, plus increases the risk of future victimization and

influences the course of recovery from mental illness. Survivors of IPV routinely present with heightened symptoms of depression, anxiety, suicidality, and overwhelming feelings of loss of control over their own lives (Warshaw, Brashler, Gil 2009).

The adverse physical and mental health impacts of IPV even extend to accessibility and affordability of health care. In comparison to women not experiencing this violence, IPV survivors exhibit increased utilization of healthcare services as a result of their heightened risk for physical and mental injury (Nicolaidis and Leibshultz 2009). Survivors typically have higher out of pocket healthcare costs as well, particularly because survivors historically represent the populations most at risk to be uninsured, or to lack access to affordable care (Anglin 2009, 88). Cost and affordability represent critical barriers to survivors seeking comprehensive services from healthcare providers. IPV also imposes a significant economic impact in that survivors lose a total of eight million days of paid work each year, resulting in millions of these survivors losing their jobs due to reasons stemming from the abuse (NCADV 2017). Coupled with high frequency of medical visits and health care costs, this employment loss further impedes survivors' ability to pay for all necessary services, and generates a vicious cycle of inaccessibility of care.

Studies of women presenting IPV to healthcare providers additionally report patterns of partners interfering with their access to health care, resulting in limited access to services, noncompliance with scheduled appointments and medications, and even retaliation for seeking care (Anglin 2009, 87). One study of women reporting IPV in a health care setting (Anglin 2009) displayed that over 17 percent reported their partners interfering with their health care, compared to two percent rate of partner interference of women not experiencing IPV (Anglin 2009; Hamberger 2009). Particularly for financially dependent survivors, such barriers exacerbate

difficulties in accessing increasingly expensive treatments and supports. This point exemplifies why it is imperative to address IPV through federal health policy, with the goal of ensuring that services reach survivors; this supports my overall research question tracing policy comparisons between VAWA and the ACA.

Examining such risk factors and health consequences of IPV underscores the necessity of focusing greater attention on survivor supports through healthcare providers and federal health policy. Understandings of both broad trends in IPV exposure and its short and long-term related health issues can be highly informative in policymaking to expand care overall, and address specific needs of survivors. In pursuit of this goal, policymakers must understand areas for improvement in existing legislation regarding violence against women, identify what services are needed to help survivors, what barriers to care currently exist, and how major policy reforms can target these coverage barriers.

B. Federal Policy Regarding Violence Against Women: History and Limitations

Regardless of the framework used to define IPV, scholars increasingly recognize that this issue has been historically under-addressed, and even ignored, in U.S. federal legislation. Legislation that does target this violence largely fails to recognize IPV as a public health issue. Contemporaneous recognition of these limitations is reflected both in heightened media attention paid to violence against women, and in a prominent increase in scholarly literature analyzing IPV best practices within the period from VAWA to the present. Prior to the 1970s, scholars, government officials, and wider society predominantly explained IPV through victim-blaming theories. Cramer (2004), Howe and Alpert (2009), Mitchell and Vanya (2009), and Sachs and Gomberg (2009) provide background to their studies of evolving health policy, and its traditional avoidance of the IPV crisis, by explaining that violent incidents were justified as private matters

within the home, with women faulted for their husband's violence. Interference by law enforcement officials or government policy was highly discouraged. By the end of the 1970s, however, activist feminist groups and domestic violence advocates opened battered women's shelters to address this "hidden problem" of domestic and sexual violence. Advocates coupled these early service provisions with a call for judicial systems to treat IPV as a formalized crime, rather than ignoring the issue as minor family feuds of little concern to policymakers (Cramer 2004, 164).

Despite substantial increases in services, funding, and government policy supporting survivors since the 1970s, IPV remains an often overlooked, underfunded problem still predominantly addressed within a narrow criminal justice framework. Rather than emphasizing services for survivors, the primary goal of the criminal justice response is to obtain a conviction of offenders (Cramer 2004; Howe and Alpert 2009; Modi et al 2014). Criminal justice policy presents few remedies beyond legal restraints, deterrence, and treatment for offenders, with no emphasis on prevention or treatment (Mitchell and James 2009). This singularly criminal justice-centered response exhibits several negative unintended consequences. Up to three-quarters of IPV survivors do not report the assault to the police--largely out of fear of law enforcement treatment or arrest and inability to pay for potential legal fees--resulting in a considerable number of women who are not being served by the criminal justice system or receiving any connections to care (Cramer 2004, 170).

Health advocates criticize the criminal justice response as ineffective and disempowering, advocating instead for a clinical, feminist, or public health intervention paradigm. In particular, the batterer intervention programs promoted by law enforcement are viewed as overly confrontational and lacking cultural sensitivity (Cramer 2004, Modi et al 2014). The criminal

justice response is one of reactionary intervention, occurring only after an assault or threat of violence. This perspective is ineffective in screening for, or preventing violence, particularly taking into account that many men who engage in abusive behaviors are not previously documented within the criminal justice system prior to perpetration. Public health advocates increasingly promote a new paradigm for addressing IPV, moving beyond this limited, offender-focused criminal justice response to one in which survivors' mental and physical well-being is the central focus. Survivors interact with the health care system on a much more regular and personal level than with the criminal justice system through both routine and abuse-related care. Providers in all settings should be prepared and resource-equipped to identify, support, and refer (Anglin 2009; O'Campo et al 2011; Oehme and Stern 2014; McCaw and Kotz 2009).

The shortcomings of maintaining the criminal justice model, rather than a public health and prevention focus, persist under VAWA legislation, reiterating the need for reexamination and reform in federal IPV policy. VAWA 1994 marked the first major piece of federal legislation specifically addressing gender-based violence, and elevating domestic violence and sexual assault to federal policy priorities (Laney 2010; Manchikanti et al 2017; Modi et al 204; Runge 2013). While Congress did conduct a series of hearings in the early 1980s to understand the scope of violence against women, culminating in the passage of the Family Violence Prevention and Services Act (FVPSA) in 1984, this law is limited in scope and in its operational definitions of violence (Fernandes-Alcantara 2017). FVPSA includes federal grants for shelter services, coordination of state and local advocates, public awareness campaigns, and a National Domestic Violence Hotline. However, FVPSA funds cannot reimburse for the provision of health services, and therefore fail to adequately address IPV as a public health crisis (Hasstedt and Rowan 2016). With the passage of VAWA 1994 (P.L. 103-122) under Title IV of the Violent Crime and Law

Enforcement Act of 1994, Congress amended the FVPSA to greatly expand federal support explicitly for domestic violence prevention and response. While the FVSPA emphasized prevention and services for victims of more generalized violence, VAWA's primary goals were to clearly criminalize rape, domestic assault, stalking, and other forms of violence against women, and to increase penalties for these acts as serious offenses (Boba and Lilley 2009; Fernandes-Alcantara 2017). Boba and Lilley note that through VAWA's passage, Congress sent the message that crimes of gender-based violence do not merely constitute private disputes, but are punishable criminal behaviors deserving of national attention.

Mitchell and James argue that the VAWA Prevent (Title IV) and VAWA Health (Title V) sections of VAWA's 2005 reauthorization were "among the first legislation to address a healthcare response or public health approach to violence at the federal level" (2009, 10). The majority of federal funding under VAWA 1994, and other legislation directed at IPV, is distributed to states for law enforcement and some community-based services. VAWA Health and VAWA Prevent, however, take steps towards a health system response to break intergenerational cycles of violence and provide resources aiding health professionals to better identify survivors (Mitchell and James 2009). Despite these initial attempts to move beyond the law enforcement model to a more comprehensive approach, VAWA largely failed to address funding and service mandates to ensure the implementation of such health services. Correspondingly, attempts to update and improve upon policy for IPV must be evaluated based on the extent to which they provide institutionalized support to promote access to health care not just in theory, but also in practice.

In moving beyond VAWA legislation, public health scholars and the Family Violence Prevention fund released a 2009 report suggesting six core components for consideration in

developing a comprehensive health policy. According to these scholars, core components include: (1) education for health care professionals, (2) protocols and policies that support health care assessment, (3) prevention of insurance discrimination against domestic violence survivors, (4) funding grants to address IPV in the health setting, (5) collaborative prevention and early intervention wellness programs, such as through CHCs, and (6) further research efforts (Macy et al 2010; Mitchell and James 2009). Grants and funding allocations, in particular, are necessary to build the capacity of health professional to identify, address, and prevent IPV, as well as to promote local, community-specific programs. As this scholarship was predominantly drafted prior to the passage of the ACA, these debates are profoundly informative in creating a standard for comparison in my evaluation of the ACA's effectiveness for survivors.

C. Addressing Intimate Partner Violence in Healthcare Provider Settings: Best Practices and the Affordable Care Act

As a significant reformation of federal health policy, the ACA represents an opportunity to improve upon VAWA's criminal justice-centered programs, shifting to a greater health, prevention, and social support focus. The ACA must be considered not only in comparison to the previously established policy under VAWA, but also in terms of the degree to which its provisions effectively implement best practices for addressing IPV. In examining legislation like the ACA, public health scholars and IPV survivor advocates address the complex question of how best to intervene in a healthcare provider setting in a manner that encourages disclosure and protects survivors from retraumatization. O'Campo et al analyzed reports by advocates exploring the inner mechanisms of health care interventions, aiming to make explicit the underlying theories of what makes IPV intervention programs effective. Defining "comprehensive" programs as those that offer numerous screening components at multiple levels and benefitting from healthcare provider institutional support, O'Campo et al identified common components of

effective interventions: thorough initial and ongoing training for healthcare providers, standardized and systematic screening protocols, and immediate access to referral or onsite support services.

Similarly, O'Campo et al, Macy et al, and others encourage this public health policy model as a way not only to support survivors, but also to diminish the treatment and disclosure barriers identified by the medical community response to IPV. In contrast to the criminal justice response, a public health response principally aims to improve survivor health outcomes. This is indicated by both increased mandates and funding allocation for services that are accessible, affordable, and comprehensive. Public health advocates' studies reveal, "the availability of support services that enable the victim to address their short- and long-term health, social, and safety needs emerged as another important component of comprehensive programs" (O'Campo et al 2011, 862). Screening and intervention protocols remain ineffectual in promoting survivors' positive health outcomes if they are not coupled with access to mental health services, safe and confidential spaces, both primary and reproductive health care, and referrals to community social service agencies (O'Campo et al 2011).

Despite broad scholarly consensus of the negative health impacts of IPV, large segments of the population are not provided with comprehensive screenings, counseling, or other services to address IPV through a health care setting. As a result, healthcare provider settings represent both an underutilized opportunity, and a site for major improvement, in the potential to identify, refer, and promote intervention to address the needs of IPV survivors. Prevention and screening efforts are undermined by the persistent stigmatization of IPV, engrained traditions of victim-blaming, the coercive nature of violence, and a deficiency of effective training, assessment tools, and community resources for healthcare providers (Anglin 2009; Iyengar 2009; Larkin and Parks

2009; Macy et al 2010; Mitchell and Vanya 2009; O'Campo et al 2011). On a personal level, IPV survivors may face denial, embarrassment, and fear of retaliation or backlash from their peers and intimate partners if they disclose abuse to healthcare providers (Anglin 2009, 90). IPV patients report fears of heightened violence or revictimization, and are consequently deterred from disclosure both by poorly trained healthcare providers, and by the potential for law enforcement involvement. Stemming from the systems of control that characterize IPV, survivors may have difficulty in trusting a healthcare provider, or may be particularly sensitive to control issues in the patient-provider relationship (Nicolaidis and Leibshultz 2009, 139). As a result, primary concerns in improving federal health policy prioritize creating an atmosphere of acceptance and validation, safe spaces to disclose and seek care, and destigmatization of abuse and mental health problems (Larkin and Parks 2009; Warshaw, Brashler, and Gil 2009).

Scholarship exploring barriers to disclosure in health settings emphasize these professional, personal, and institutional barriers for the healthcare provider in positively encouraging IPV disclosure and intervention. Healthcare providers at all levels, including emergency care workers and primary care providers, not only exhibit misconceptions about the nature of IPV, but demonstrate personal biases, and subscribe to the persisting belief that IPV is a private, rather than public health or healthcare issue (Macy et al 2010). These personal barriers effectively inhibit medical professionals from implementing screening and prevention for their patients. Personal biases and fears of offending patients are coupled with substantial professional barriers, including appointment time constraints, ineffective training about interventions, and lack of appropriate services to which to refer patients (Anglin 2009, 90).

Recognizing the limitations of existing services, advocates center their recommendations for programs essential to survivors based on both past experiences working with survivors, as

well as on the recommendations of several comprehensive studies by the Institute of Medicine (IOM), the United States Preventive Services Task Force (USPSTF), and other national healthcare organizations. In 2011, the IOM released a report highlighting the prevalence of IPV in the U.S., and recommending “screening and counseling for all women and adolescent girls for interpersonal and domestic violence in a culturally sensitive and supportive manner” (Miller et al 2015, 92). Within the broader public health community, screening is defined as “the use of a test, examination, or other procedure rapidly applied in an asymptomatic population to identify individuals with early disease” (Miller et al 2015, 93). However, IPV remains such a stigmatized and “silent” problem that many survivors are not truly asymptomatic when screened; patients exhibit a pattern of suppressing or hiding symptoms in order to avoid this stigmatization. Effective screening within the IPV context therefore requires healthcare providers to be armed with the necessary tools for sensitive, informed, and empathetic inquiry.

Screening for IPV involves careful navigation of multiple levels of patient interface and intervention. This involves primary prevention for patients with no history of exposure, secondary prevention addressing patients with past exposure, and tertiary prevention efforts for patients with current or emergent experiences of violence (Howe and Alpert 2009; Miller et al 2015). Settings that provide 24-hour on-site advocacy, community collaboration with external domestic violence advocates, adoption of protocols for routine inquiry, and ongoing multidisciplinary training have indicated the most improvement in care provisions. This improvement is exhibited through measures such as increased rates of routine inquiry, case finding, referrals, provider self-efficacy, and even rates of patient satisfaction with provider care (Larkin and Parks 2009; 314). To best address survivors at multiple levels of violence exposure, and to mitigate the personal and institutional barriers to screening and counseling, scholars

emphasize the need for greater training, education, and resources for healthcare providers. Best practices promoting survivor safety, confidentiality, and connection with comprehensive counseling services must be coupled with primary care clinics hiring of specialized staff members dedicated to IPV interventions.

The ACA is distinct from previous legislation addressing IPV, and from prior health policy legislation, in general, in that it centralizes convergence of wellness and prevention, as opposed to reactionary or disease treatment-focused interventions (Jacobson and Dahlen 2016; Mayer et al 2015; Oberlander 2016; Oehme and Stern 2014). Despite several implementation challenges, including difficulties in establishing new institutions, educating the public, and persuading reluctant policymakers, (Beland et al 2016; Corman and Levin 2016; Oberlander 2015), the ACA's targeting of persistently uninsured and underserved communities makes it a central piece of legislation to effectively study the ability of federal health policy to improve well-being of individuals who are survivors or at risk for violence (Atsas and Kunz 2014; Beland et al 2016; Sonfield and Pollack 2013; Stolp and Gox 2013; Williams 2016). Specifically, the ACA's special provisions bolstering care for at-risk communities allow for expansion of reproductive care services and service utilization (Mears and Visser 2005; Stapleton and Skinner 2015; Stulberg 2013). As noted by Stulberg, the ACA "has great potential to improve the reproductive health of the U.S. population. Expanded coverage of young adults and the reproductive health services they seek will not only benefit current patients but will allow us to learn and improve care for the benefit of future users" (2013, 453). Gee (2012) and Sonfield et al (2013) expand upon the conclusions of scholars who examine ACA implementation more broadly, further detailing potential gains and serious challenges to the ACA's treatment of reproductive health, and, consequently, IPV survivor health.

Drawing together these three categories of literature related to IPV health effects, the evolution of federal policy addressing violence against women, and best practices for medical providers' response to IPV reveals a noteworthy gap in comprehensive services addressing long-term health needs of survivors, including at CHCs. While the VAWA and its three reauthorizations provide vital resources to survivors, since this legislation was formulated within the criminal justice model, it consequently lacks a central focus on wide-ranging health policy. As the ACA marks the most far-reaching reform of health policy and funding since VAWA, I study this legislation with a critical eye to determine the extent to which the ACA effectively satisfies the core components and best practices of comprehensive policy called for by the public health community. In particular, this analysis focuses on the provisions of the ACA related to providing care for survivors in an affordable, community-centered, coordinated manner. I pay heightened attention to the ACA's mandate for services, funding, and enforcement within the context of federally qualified CHCs as sites of greatest potential impact.

Research Design and Methodology

I conduct qualitative, inductive research into the relationship between health policy under the ACA and federal provisions for IPV survivors, focusing on survivors' access to care. My central research question is: How does the ACA address IPV and its health impacts on survivors? Sub-questions supporting my overall research include: (a) Is there evidence that this legislation positively impacts access to health services for survivors, utilizing VAWA as a baseline for comparison, (b) how has the ACA impacted service mandates and funding for survivors, specifically within CHCs, and (c) what is the relationship between the ACA and potential long-term health effects and outcomes of IPV survivors? In crafting an effective research design to address these questions, it is crucial to recognize that the ACA remains a fairly new piece of

legislation. Signed into law in 2010 and fully implemented beginning in 2014, the vast majority of the ACA's mandates have not yet been in place for a sufficient time period to allow for an accurate study of long-term implementation implications. As a result, conducting deductive research in an attempt to prove causality between ACA policies and improved services or health outcomes for survivors is beyond the present scope of my study. Rather, I acknowledge the existing limitations that inhibit deductive study quantifying or proving this relationship in such initial analyses of the ACA's early impact, and thus specifically map out the relationship between the ACA's health policy reforms and IPV survivors through inductive reasoning.

A. Evaluating IPV Legislation and Policy

Exploring this relationship necessitates a deeper understanding of the legislative and policymaking process. My research design aims to explicate the formulation and evolution of federal health policy addressing IPV from VAWA to the ACA. This legislative analysis includes advocate and public health expert input, budget considerations, and federal mandates. I center my research design on inductive research through the qualitative methods of textual analysis, case studies, and examination of compiled secondary data. A qualitative research design is consistent both with the goal of this project in laying out the development and progression process of IPV policy, and also with the methodology used by existing scholars analyzing federal responses to this issue. The works of Runge (2013), Oberlander (2016), Sonfield and Pollack (2013), Boba and Lilley (2009), and others informed my own emulation of their legislative process tracings. These scholars rely heavily on qualitative, direct textual analysis of public statutes, as well as legislative histories and government reports, in order to substantiate claims made in their analysis about a particular policy.

However, each of these scholars uses legislative history research frameworks to analyze

only one particular piece or aspect of legislation related to IPV, or to provide a very broad policy overview of statutes. My project diverges from existing research to the extent to which I delve into the legislative history of specific sections of multiple laws that pertain to IPV survivor and health care; both policy researchers and developers heretofore inadequately addressed the interconnections of this issue. Conducting legislative histories on the most significant bills addressing violence against women and health policy, coupled with a case study of these bills' impact on CHCs, constitutes the primary portion of my original data collection. Currently, scholars Runge (2013) and Modi et al (2014) offer the most comprehensive evaluations of federal policy aimed at prevention and treatment for violence against women, and Sonfield and Pollack (2013), as well as other scholars, provide the most updated analyses of the ACA and its initial implementation effects. However, gaps remain in that no research has yet brought all of the relevant policies and literatures together to explore this specific relationship. I fill in the gaps remaining in current scholarship by synthesizing (1) legislative histories, (2) analysis of government reports and secondary data, and (3) funding allocations for programs in CHCs, to create a detailed, process-tracing review of healthcare for IPV survivors.

To conduct this analysis of health policy aimed at IPV, I use VAWA 1994 and its subsequent 2000, 2005, and 2013 reauthorizations as a baseline for comparison of the ACA's dictated policies and anticipated effects. As discussed in the Literature Review, state and federal lawmakers increasingly recognized domestic and sexual violence as a public health problem following the 1970s push of women's rights activists and the battered women's movement (Runge 2013). However, violence against women largely remained conceptualized as a problem of the private sphere, rather than as a federal policy priority. There is widespread consensus among public health, public policy, and women's rights fields that VAWA 1994 represented the

first comprehensive piece of major federal legislation drafted specifically to address issues of gender-based violence (Mitchell and James 2009; Runge 2013). Therefore, my study of the ACA's potential changes in domestic violence and sexual violence policy must be grounded in a process tracing of VAWA's evolving provisions relating to IPV and health care. As Literature Review scholarship addresses, VAWA's original formulation insufficiently addressed IPV's health consequences, solely encouraging a stronger criminal justice response. Similarly, Congress initially reauthorized VAWA as part of the Victims of Trafficking and Violence Protection Act of 2000, which added initiatives to assist victims of dating violence, elder abuse, and domestic violence targeted at individuals with disabilities, but did not contain any health policy provisions or services (Laney 2010; Runge 2013).

It was not until the Violence Against Women and Department of Justice Reauthorization Act of 2005 that federal legislation expanded support for IPV responses to include collaboration with health care professionals (Runge 2013). VAWA 2005 represented the most far-reaching expansion of federal IPV policy, addressing additional forms of violence including domestic violence, sexual assault, dating violence, stalking, elder abuse, and child abuse and neglect more effectively than previous legislation (Runge 2013, 438). Based on these factors, as well as the fact that the 2005 reauthorization was the last version passed prior to the passage of the ACA in 2010, I center my textual analysis principally on programs established under VAWA 1994 through VAWA 2005. My process-tracing legislative history considers VAWA 2013, however, to the extent that my research question necessitates a complete understanding of how the ACA's strategy addressing IPV may differ from policy established under other federal statutes.

Using VAWA as my standard for comparison, I study the ACA in part because of IPV advocates' criticism of VAWA as not going far enough to prevent and mitigate IPV. Following

VAWA, the ACA marks the most significant piece of federal legislation including provisions to address violence against women. This legislation is valuable to explore in relation to IPV because of the historic deficiency in legislators and policymakers' considerations of IPV health effects. Drawing on existing scholarship, it is clear that both deeper research and further policy development are required in exploring the relationship between IPV and federal policy beyond the limited criminal justice lens.

B. Conducting Legislative Histories

I begin my study of evolving federal IPV policy from VAWA to the ACA by collecting all relevant documents comprised in an official legislative history. Legislative histories include basic descriptive elements of the law subject to analysis: bill number, Congress number, popular or common name, significant dates of consideration and passage, related bills, and bill sponsors. I gather the Congressional Record (CR) index for each law, as well as the Congressional Record of Debates, committee hearings and reports, and a summary of the enacted public statute. Government reports and hearings are essential to answering my research question in that they provide important background, and offer a detailed account of each law's drafting considerations and evolution. In particular, committee reports and hearings allow me to see whether IPV was of special focus, or emphasized, in drafting of policies related to increasing care affordability, reducing insurance discrimination, and promoting access to services aimed at improving survivor health outcomes.

Looking at the legislative history of the ACA requires particular attention to the records of the following committees in both congressional chambers: (a) the Committee on Health, Education, Labor, and Pensions (b) the Committee on Energy and Commerce Subcommittee on Health, as well as the (c) House Ways and Means Committee Subcommittee on Health, and (d)

the Senate Finance Committee. I utilize transcripts of Committee hearings and debates of each bill, therefore providing context and clarifying questions potentially raised or unresolved by a reading of solely the actual bill text. Careful examination of committee hearings leading up to the passage of VAWA and the ACA allows me to understand the meanings of particular provisions related to IPV, why such provisions were included, and which scholars and factors were considered by each bills' sponsors in drafting the legislation. I conduct a latent content analysis of the committee hearings to examine the implicit motivations for inclusion of relevant provisions. In particular, I use committee reports and hearings to further understand the extent to which best practices for IPV survivors informed legislators' crafting of ACA health policy, ACA service mandates, and funding allocations to programs and sites potentially most impactful for survivors, such as CHCs.

To complete this research, I accessed the Congressional Record Index for VAWA and the ACA through the online records of congress.gov. The Congressional Record (CR) is the official account of daily legislative activity of each chamber and its committees, Member remarks, communications from the president, and supporting documents. Congress.gov provides full-text access to daily CR issues dating from 1995, beginning with the 104th Congress. However, as VAWA 1994 was passed prior to this date of online records, I additionally use information from databases outside government-compiled records. I collected the documents and transcripts necessary to a complete legislative history using UConn library website access to the databases of HeinOnline and ProQuest Congressional Publications.

After organizing the necessary documents to complete my legislative history analysis, I search each law for the relevant sections explicitly focused on IPV, domestic violence, or sexual violence; services for survivors; and funding for these services. I conduct this search through an

online keyword search of the following terms, identified based on the their utilization in public health and public policy scholarly literature related to IPV:

- a) “Women”
- b) “Battered women”²
- c) “Violence against women”
- d) “Intimate partner violence”
- e) “Sexual violence”
- f) “Sexual assault”
- g) “Domestic violence”
- h) “Family violence”
- i) “Dating violence”³
- j) “Preventive care services”
- k) “Comprehensive services”
- l) “Community health center”
- m) “Federally qualified health center”
- n) “Community-based services”

In addition, my analysis of each legislative history considers both the “related legislation” listed in the CR Index, as well as the previously existing legislation amended by passage of each public act. This latter consideration is particularly significant to reveal the relationship between the ACA and IPV policy, and how this policy represents a change, and possible improvement, from preceding policy under VAWA.

C. Case Study: ACA Provisions and Community Health Centers (CHCs)

Using the legislative history as starting point, I delve into a deeper exploration of the provisions of the ACA, looking at two specific aspects that have the potential to affect health care of IPV survivors: service mandates, and funding for these services. As the ACA marked an extremely extensive policy reform by overhauling the health insurance structure, addressing each

² Contemporary discourse surrounding IPV primarily uses the term “survivor” in reference to individuals exposed to IPV. However, prior to the passage of the ACA, legislation and policy debates addressing IPV predominantly discussed the problem solely as a “women’s issue.” During the period in which VAWA 1994 was drafted and passed, IPV survivors were therefore commonly referenced as “battered women.” I include the search term “battered women” in this study to ensure that I identify a comprehensive, exhaustive list of relevant sections of VAWA 1994.

³ While I do not focus specifically on dating violence, which is a distinct type of IPV, in the context of this paper, this term is important to include in searching for relevant sections of VAWA and ACA legislation, as it is often referenced in conjunction with both safety concerns and health consequences of IPV.

of the numerous changes in services, and assessing the service's relationship to IPV survivor health, is beyond the scope and feasibility of present study. To narrow my focus, I look at changes in services provided, and funding levels for these services for survivors, exclusively in the context of federally qualified community health centers, or CHCs. Studies of CHC public health implications show that utilization of primary care is associated with improved receipt of preventive services and screenings, management of chronic conditions, reduced use of expensive emergency services, and improved overall general health outcomes (Hatch et al 2016; Iyengar Sabik 2009; Tiefenthaler et al 2005).

CHCs serve as an exemplary case study to elucidate the relationship between the ACA and survivors' access to comprehensive health care, as these sites primarily serve the commonly most underserved and persistently uninsured populations. In fact, the majority of CHCs' patients either lack insurance coverage or rely on Medicaid coverage (Adashi et al 2010; Hatch et al 2016). CHCs are also typically embedded within rural communities and under-resourced urban centers in order to target individuals and families most limited in care options. The majority of patients treated at CHCs are low-income, women, children, and uninsured: thus, patients represent the very population targeted by ACA interventions (Adashi et al 2010; Hatch et al 2016; Williams 2016). IPV survivors represent an intersection of these most vulnerable populations, in that survivors are predominantly women, lower-income, and routinely denied access to medical care and insurance as a result of negative characterizations of IPV victims. As a result, CHCs are sites at which the ACA has the most enhanced potential to be impactful in helping survivors; studying CHCs is fundamental to answer my principle research question. As an exemplification of the ACA's aim to intervene on behalf of the underserved, including IPV survivors, CHCs are tied to important comprehensive services aimed at mitigating IPV. CHCs

are premised on going beyond primary care to present an accessible, coordinated approach to healthcare (“About Our Health Centers”). As described by Adashi et al (2010, 2049) and other public health scholars, CHCs provide a whole-person orientation to care, going beyond basic emergent care for IPV survivors to address compounding health concerns stemming from violence exposure.

As the purpose of this study is to examine how the ACA addresses IPV, and whether there is evidence that the ACA positively impacts survivor health and access to services, it is necessary to draw upon the writings of IPV advocates to develop a list of the “comprehensive services” required to fully and effectively address IPV through health policy. Consequently, as I study CHCs both before and after ACA policy, I explicitly compare the availability and funding of the following “comprehensive services:”

- a) Primary care and dental services
- b) Behavioral and mental health professionals trained at IPV interventions
- c) Mandated preventive screening policies
- d) Counselors, including counseling on health relationships
- e) Substance abuse programs
- f) Pharmacists
- g) Reproductive healthcare services
- h) Social workers and/or case management
- i) Victim advocacy programs
- j) Referrals to community agencies: shelter services, children’s support programs, legal assistance, transportation, etc

To be defined as “comprehensive,” the preceding services must be ideally delivered onsite at CHCs, be both confidential and financially accessible, and must address the intersecting short and long-term physical, emotional, and psychological health impacts of violence. These “comprehensive services” must be supported by ongoing training and education for health care providers, federal guidelines and IPV assessment tools, and safety planning policies.

Most significantly, CHC services for survivors must be evaluated based on whether

federal funding is allocated to support staffing, training, service implementation, and any other expansions related to complete IPV health care. In order for the ACA to have a real impact on survivors and their health, its potential advancements must come in the form of funded mandates, as opposed to unfunded guidelines; promotion of “comprehensive services” is ineffective without provisions facilitating their implementation. Unfunded mandates fail to solve existing health policy problems addressed in the Literature Review; CHCs lack the capacity to effectively screen for abuse, add additional programs, or hire and train new specialized staff in the absence of federal funding. As a result, following this paper’s overall examination of CHC services provided nationwide pre-versus post-ACA passage, I explore the additional factor of whether services are financially accessible to IPV survivors.

I assess service expansions and funding allocation through textual analysis of the relevant portions of the ACA regarding CHCs, as well as through government and non-governmental organization reports, and other secondary data sources. Utilizing internal documents from the federal government as the crafter of the ACA and the source of its funding, I compile reports from the Congressional Budget Office (CBO) and the Congressional Research Service (CRS) detailing areas where the ACA amends previous legislation and impacts CHC budgets. The CBO is a nonpartisan office that provides budgetary and economic information to inform the legislative and policy process, including budget projections, cost estimates, analytic reports of federal spending programs, scorekeeping of legislation, and analysis of federal mandates. CBO reports prove valuable to my research methods in that they provide an objective description of ACA economic impact, and funded versus unfunded service mandates. CBO and CRS reports also advance my research by providing information on the availability and funding of the previously listed comprehensive services within CHCs, and in describing the budget impact of

the ACA on CHCs nationwide. Similarly, as a nonpartisan office working to provide policy and legal analysis to Congress, the CRS serves as a vital resource both in policymaking, and in informing my understanding of the development of health policy for IPV survivors under both VAWA and the ACA. I support the CBO and CRS data with reports drafted by the US Preventive Services Task Force, the Office of Violence Against Women under the U.S. Department of Justice, as well as the Department of Health and Human Services (HHS). Finally, I utilize NGO data analysis of CHC services, including the National Women's Law Center, Futures Without Violence, the Kaiser Family Foundation, the Guttmacher Institute, and the Institute for Women's Policy Research, to supplement the analyses provided by federal reports.

D. Strengths and Limitations

The depth and breadth of both the data that I research, and the sources from which I pull data, are a significant strength of my research methodology. By beginning with a legislative history and textual analysis of both bill text and congressional hearings, I go directly to the source of federal health policy to reveal the factors or frames policymakers considered in their agenda-setting and policy formulation. As this textual analysis is contextualized within a process tracing of legislative change from VAWA to the ACA, my study for the first time lays out the evolution of how IPV is considered and addressed in some of the most major, consequential pieces of federal legislation of the last three decades. In going beyond solely legislative histories to additionally analyze secondary data sources, I draw upon both objective analyses, and analyses conducted by experts in the fields of public health and violence against women, therefore adding legitimacy to my own interpretations. My research design is thorough in its inclusion not just of a comparison of accessible services before and after ACA implementation, but also of an assessment of whether these services are (a) comprehensive, (b) adequately

address IPV's negative health effects, and (c) are supported by federal funding to facilitate implementation.

Despite these strengths, a few potential gaps in my research design represent potential directions for further research, particularly once the ACA has been implemented for a sufficient period to permit more causal study. Primarily, my study is limited in its scope to look solely at the legislative provisions provided by the ACA, rather than additionally considering problems of implementation of these provisions nationwide. While it may be argued that ACA implementation varies widely by state, particularly as a result of states differing in their decisions on Medicaid expansion, the creation of state health insurance exchanges, and the prevalence of CHC utilization, considerations of implementation are beyond the scope of the present study. As I explore how the ACA, as written policy, addresses IPV from a health-based perspective, I purposefully narrow this study to textual analysis. Plus, only eight years after its passage, ACA's long-term implementation effects cannot definitively revealed.

In addition, some scholars may criticize my use of funding for services as a factor explicating the ACA's impact on survivors. While funded mandates and federal funding allocations do not necessarily directly correlate to more accessible services or positive health outcomes, the inclusion of budget considerations in my study advances beyond existing scholarship. My research represents a significant first step and preliminary articulation of the relationship between the ACA and IPV; while future research will be able to go further in understanding ACA implementation and effectiveness, it is important to conduct this early analysis of the ACA to help shape better policy formulation, and to inform potential strengthening or reform of existing ACA provisions. The identified potential gaps in the present study facilitate directions for future inquiry into the long-term health impacts of the ACA on IPV

survivors, the personal experiences of IPV survivors at CHCs under the ACA, and, eventually, a deductive determination of whether or not the ACA causally marks an improvement from previous federal health policy.

Data and Results: Legislative Histories of VAWA and the ACA

A. Introduction to Legislative Histories

In this section of the paper, I conduct legislative histories of both VAWA and the ACA, for purposes of clarifying information relevant to understanding the IPV health care policy crafted by each statute. Legislative histories are essential to my analysis of the ACA and its impact on health care access for IPV survivors in that these histories provide context for bill crafting and passage. Legislative histories act as a compilation of the documents and information produced by Congress as a bill is drafted, introduced, debated, and considered. Legislative histories include several types of legal and legislative documents, including committee reports, committee hearing documents, transcripts of floor debates, and drafts of the bill text, itself (Legislative History Research Guide, 2016). Committee reports provide important background and offer a detailed account of bill's legislative evolution, while hearing documents are transcripts of actual debates that took place on bills. Both documents serve to clarify questions raised by reading only the bill text, such as the explicit meanings of a particular provision, and why it was included. Put simply, a complete legislative history traces the chronological steps the legislation followed through Congress, and the materials that explain what happened during each of these steps of the legislative process.

Legislative histories provide vital insight into the background and events leading to the enactment of a statute. Legislative histories are primarily recorded to aid interpretations of the legislative process, and the laws the subsequently emerge from this process. Beyond strictly

textual interpretation, legislative histories allow researchers to discover which committees and Members were involved in the bill's passage, how the legislative language evolved or was amended as it advanced through the congressional process, and how Members voted on both proposed amendments and on final passage. A complete understanding of the creation of healthcare-focused statutes, including the potential partisan and policy-based motivations behind the inclusion of certain language or amendments, will help deepen my analysis of how health policy for IPV survivors evolved since the passage of VAWA 1994. For the purposes of the present research focus, I compile and compare legislative histories of relevant sections of VAWA 1994⁴ and the ACA (2010). For each piece of legislation, I provide a summary of relevant sections of bill text, thereby establishing information necessary for textual analysis and comparison of the statutes in the Analysis section of this paper⁵. This deeper examination of both VAWA 1994 and the ACA allows me to look at the legislation through a lens of the historical context at the moment of each respective statute's drafting. I use a comparison of VAWA and the ACA's legislative histories to show that while the ACA primarily aimed to reform the health care insurance and delivery systems in general, the ACA also much more specifically addressed the long-term health care needs of IPV survivors than did VAWA 1994.

⁴ As noted in the Background and Literature Review sections, VAWA 1994 requires congressional reauthorization, resulting in three reauthorizations in 2000 (P.L. 106-386), 2005 (P.L. 109-162), and 2013 (P.L. 113-4). For the scope of this paper, I primarily discuss VAWA 1994, as this statute serves as the baseline for comparison in understanding how ACA provisions change, go beyond, and potentially improve upon the VAWA provisions. I additionally include a succinct analysis of relevant portions of the Violence Against Women and Department of Justice Reauthorization Act of 2005, as this legislation marked the first time that federal policy targeting violence against women expanded to include health care-focused provisions. It is beyond the aim of this paper to discuss VAWA 2000, which produced little change from VAWA 1994, or to include an analysis of VAWA 2013, which was passed after the ACA (2010) and similarly includes few provisions related to IPV and health policy.

⁵ In conducting legislative histories of these two laws, I use databases of HeinOnline, ProQuest Congressional Researcher, and the Congressional Research Service. The sources I use include the text of scholarly articles describing the two specific bills and their implementation, accompanied by scholarly articles process-tracing the evolution of federal health policy both in general, and specifically in reference to IPV. See the Research Design section for further detailed explanation of methods employed.

I begin with a legislative history of VAWA 1994, as this law serves as the baseline for comparison in understanding how ACA provisions change, go beyond, and potentially improve upon the VAWA provisions. The legislative histories included in this section provide a general overview of the major policy provisions and programs established under each law, but place primary emphasis on the sections of the statutes that specifically reference the forms of family violence that fall within the definition of IPV. I conducted a complete legislative history of the VAWA 1994 bill, but for this scope of this work I narrow in on the specific documents most relevant to advancing my argument. The majority of this section emphasizes VAWA's treatment of domestic violence and sexual violence by intimate partners, and the programs and grants created. By conducting this legislative history, I reiterate the point made in the Literature Review that VAWA did not address IPV with survivor health outcomes in mind, but rather from a criminal justice lens.

Next, I conduct a legislative history of the ACA, beginning with a concise overview of the overall purpose and outcome of the law, followed by a more detailed explanation of the sections of the statute addressing women's health, IPV, family violence, and preventative health care. This includes 12 statute sections that amend VAWA, and that address IPV, CHCs, prevention tools and comprehensive services, and funding for these services. As the central question of this thesis centers on how the ACA addresses IPV, this portion makes up the most significant section of the legislative history component of my research design.

Finally, I conclude the legislative history section of this paper with a textual analysis and comparison of two main statutes studied: VAWA 1994 and the ACA. An understanding of this evolution, beginning with VAWA 1994's criminal justice provisions toward a more preventative,

health-centered approach to policy allows an analysis of the ACA with an eye to whether the ACA marks a change and advancement from previous policy.

B. Legislative History of the Violence Against Women Act of 1994 (VAWA)

I. Bill Information and Timeline of Actions

The Violence Against Women Act of 1994 (VAWA) (Title IV, sec. 40001-40703, P.L. 103-322) was introduced, considered, and enacted by the 103rd Congress (1993-1994) as part of the larger Violent Crime Control and Law Enforcement Act of 1994. Rep. Jack B. Brooks (D-TX-9) introduced the bill, H.R. 3355, on October 26, 1993. H.R. 3355 was cosponsored by Rep. Charles E. Schumer (D-NY-9) on October 26, 1993, and by Rep. William J. Hughes (D-NJ-2) on November 11, 1993. The official title of the bill as introduced in the House of Representatives: To amend the Omnibus Crime Control and Safe Streets Act of 1968 to allow grants to increase policy presence, to expand and improve cooperative efforts between law enforcement agencies and members of the community to address crime and disorder problems, and otherwise to enhance public safety. The popular title for Title IV, the portion of the overall crime bill addressing IPV, was the Violence Against Women Act of 1994 (VAWA 1994). While VAWA 1994 was part of a much larger, all-encompassing piece of legislation aimed at reducing crime, this legislative history focuses on the sections of Title IV of H.R. 3355 that advance my argument. There are no amendments to the VAWA sections of this legislation.

Following its introduction in the House, H.R. 3355 was reported to the House Committee on the Judiciary and was agreed to by voice vote in the House on November 3, 1993. The Senate passed H.R. 3355 by a vote of 95-4 on November 19, 1993. The Senate passed this House version of the Violent Crime Control and Law Enforcement Act in lieu of a related bill, S. 1607, introduced in the Senate by Senator Joseph R. Biden Jr. (D-DE). A conference committee met in

June and July of 1994 to resolve differences in Senate and House amendments to the legislation, resulting in the filing of conference reports H Rept. 103-94 on August 10, 1994 and H Rept. 103-711 on August 21, 1994. The conference report was agreed to in the House by a recorded vote of 235-195, and in the Senate by a Yea-Nay vote 61-38. Finally, H.R. 3355 was presented to President Bill Clinton on September 12, 1994, and signed into Public Law 103-322.

II. Committee Hearings

Prior to consideration on the House and Senate floors, H.R. 3355 was referred to the House Committee on the Judiciary and the Senate Judiciary Committee. Each respective committee held several hearings regarding the proposed drafts of the legislation, through which lawmakers took heed of the policies supported by domestic violence advocates. The House Committee on the Judiciary Subcommittee on Civil and Constitutional Rights conducted a hearing on “Crimes of Violence Motivated by Gender” (HRG-1993-JJH-0052) on November 16, 1993. As revealed by its report, this hearing focused on Title III of the overall crime control bill, to establish a civil rights cause of action for civil suits against persons who commit sexual assault and other gender-motivated crimes.

Most significant for the purposes of this work was the hearing “Implementation of the Violence Against Women Act,” held by the Senate Committee on the Judiciary on September 29, 1994, two weeks following the Act’s passage (HRG-1994-SJS-0029). The Senate Judiciary Committee conducted this hearing to examine VAWA’s implementation process, specifically focused on service and funding mandates for programs to aid survivors of domestic violence. During the course of this hearing, lawmakers heard from two panels of witnesses to discuss both advancements and shortcomings of the newly enacted legislation. The first witness panel offered perspective on ways of dealing with domestic violence against women, and co-occurring issues

related to domestic violence victimization. A second witness panel offered a description of programs serving survivors of domestic abuse and sexual assault in Schuylkill County, Pennsylvania, as an exemplar case in government supports for survivors. These panels' arguments are noteworthy in that IPV advocates immediately identified areas for improvement in the VAWA legislation, including necessity for more all-encompassing support services for survivors, beyond the criminal justice perspective.

III. Committee Reports

The House Judiciary Committee served as the central committee during drafting and consideration of Title IV of P.L. 103-322. The House Judiciary Committee issued four key reports relevant to the purposes of this legislative history. On November 3, 1993, H.Rept. 103-324, "Public Safety and Community Policing: "Cops on the Beat" commended the VAWA 1994 bill's prioritization of a community-coordinated response to IPV. Through this report, the Committee recommended passage of H.R. 3355 to amend the Omnibus Crime Control and Safe Streets Act of 1968. Next, H.Rept. 103-395 of November 20, 1993 recommended passage of the related legislation H.R. 1133 Violence Against Women Act of 1993. Following the passage of the overall crime bill H.R. 3355 by the House of Representatives, the House Judiciary Committee issued H.Rept. 103-694 on August 10, 1994. This report, accompanied by H.Rept. 103-711 from August 21, 1994, acts as the conference report on H.R. 3355, reconciling the differences in definitions and provisions outlined by the House and Senate versions of the bill.

IV. Congressional Record of Debates

The Violent Crime Control and Law Enforcement Act of 1994, including the Title IV VAWA statute, was debated for 40 minutes on the House floor on November 3, 1993. During debates on this legislation, members of the Republican caucus argued that the crime bills up for

consideration did not go far enough, were written in an overly partisan manner, and failed to impose strict penalties. Rep. Sensenbrenner, Jr. (R-WI-9) argued that the proposed anticrime bill's measures "do not do anything as their response to the problems that are so touching our constituents," including neighborhood safety and domestic abuse (H8718). Rep. Sensenbrenner additionally criticized the bill for including several unfunded mandates; in the absence of robust anticrime funding, Rep. Sensenbrenner argued that the bill's intended effects would prove ineffective. To conclude his floor speech, Rep. Sensenbrenner made the point that a myriad of bipartisan proposals purposed to mitigate violence against women were being held up in committee. The Member argued, "the victims' rights proposals, they have gone to subcommittee, I guess to wait for Santa Claus to come down the chimney, because they will be sitting there at Christmas and New Years, and more victims will not be able to address the court when the sentence is imposed upon people who have committed crimes against them" (H8719). Following this debate, subsequent versions of the bill placed greater emphasis on securing victims' protections and legal assistance, culminating in the form of VAWA passed the next September.

V: Presidential Message and Signing Statement

In his September 13, 1994 Remarks on Signing the Violent Crime Control and Law Enforcement Act of 1994, President Clinton provided no specific mention or presidential message on VAWA, or on any of P.L. 103-122's provisions addressing IPV. Exemplifying how IPV was not a top priority in the federal government's drafting of the 1994 crime bill, President Clinton instead focused strictly on criminal justice measures of supporting law enforcement, crime reduction, banning assault weapons, and other measures.

VI. Summary of Public Law 103-322

Title IV of the Violent Crime Control and Law Enforcement Act of 1994, commonly

referred to as the Violence Against Women Act of 1994, was reported out of the House Committee on the Judiciary and agreed to by voice vote in the House of Representatives on November 3, 1993. Subsequently, H.R. 3355 passed in the Senate by a vote of 95-4 on November 19, 1993. VAWA 1994 passed the Senate in lieu of S. 1607, the version of the crime control bill introduced in the Senate under the 103rd Congress. As enacted, VAWA 1994 incorporated provisions from related legislation, including the proposed H.R. 4092 version of the Violent Crime Control and Law Enforcement Act of 1994, in addition to bill drafts considered under the previous Congress.

The Violence Against Women Act of 1994 was enacted to establish a “national response to the epidemic of violence against women” (Runge et al 2013, 435). At the time of VAWA’s original drafting and passage in 1994, violence against women was not recognized as an official crime. VAWA 1994 takes the important step of formally recognizing violence against women as a national problem. Policymakers in support of VAWA 1994 “hoped the Act would change the attitudes of people who have traditionally been insensitive to crimes of violence against women and who view those crimes as less serious than others” (Boba 2009, 169). The legislation created a definition of “violence against women” that largely reflected the widely held understanding for domestic violence at the time. The established definition incorporated the federal felony definition of sexual abuse, and additional language recognized that a majority of perpetrators are known by their victims, often as their intimate partners. In this way, VAWA marked a departure from previous conception of sexual assault as occurring only predominantly by “strangers jumping out of the bushes,” preying on isolated women.

VAWA 1994 was constructed on two overarching goals: (1) to enhance investigations and prosecutions of violent offenders, and (2) to provide for grant programs to address violence

against women through a coordinated community response, based largely on law enforcement (Aday 2015, 8). VAWA 1994 amended existing federal criminal law, intending to provide additional protections to survivors of domestic violence, sexual assault, and stalking, and to bolster protections provided under state laws. VAWA 1994 created penalties for interstate stalking and domestic abuse, strengthened existing penalties for repeat sex offenders, created new evidentiary rules, and permitted sexual assault survivors to demand that their alleged assailants be tested for HIV (Laney 2010, 2). The statute required a federal court that convicted an individual under its provisions to issue a restitution order, granting remedies to survivors including attorney fees, transportation costs, and, in certain cases, temporary housing and funding for medical services (Subtitle E, Section 40504). The statute established federal grants to cover three areas of focus, with investigations and prosecutions receiving the majority of funding at \$1.6 billion over a five year period, accompanied by funding for victim legal services and violence prevention. This exclusive emphasis on criminal justice services in these funding mandates establishes a baseline against which to contrast the health policy provisions of the ACA. Agencies administering these grants include the Office of Justice Programs, the Department of Justice, the Center for Disease Control and Prevention (CDC), and the Office of Violence Against Women (OVW) formed under the statute's directive (Aday 2015, 8).

Title IV, Subtitle A, Chapter 5: "Assistance to Victims of Sexual Assault" marks the first section of the legislation specifically providing assistance to survivors, as opposed to focusing on perpetrators of violence. This provision amends the Public Health and Human Services Act to allow States to use block grant funding for rape prevention and education programs to conduct educational seminars, operate hotlines, host training programs for professionals, and other efforts to increase awareness and help prevent sexual assault. Sections 40152 through 40156 outline

additional mandates for training for law enforcement, and other professionals. For example, Section 40153 directs the Attorney General to evaluate the manner in which States protect the confidentiality of communications between IPV survivors and therapists, trained counselors, and other health professionals.

Title IV, Subtitle B: “Safe Homes for Women Act of 1994” amended the Family Violence Prevention and Services Act (FVPSA) to authorize the Secretary of HHS to establish a National Domestic Violence Hotline. Chapter 6 of this section further amends FVPSA to direct the Secretary of Education to provide grants to nonprofit organizations to establish community programs on domestic violence. This section is highly significant to understanding both VAWA’s mission and goals, as well as how the ACA later built upon these goals, by providing for a coordinated community prevention and intervention response to IPV. This coordinated response highlighted the need for heightened supports for survivors beyond crisis services provided in the immediate aftermath of an incidence of violence. The Safe Homes for Women Act of 1994 functions as a major component of VAWA 1994 by initiating renewed prioritization of efforts to combat violence against women through commissioned studies aimed at improving understanding of this complex issue. Chapter 9: Data and Research convened a panel under the National Academy of Sciences to study IPV and its effects on both individuals and on wider society. This provision directs states to collect centralized databases on incidence of sexual violence and domestic violence, and to set forth reporting requirements for such crimes (Sec. 40292). Of most significant note, Section 40293 required the Secretary of HHS to study, and recommend, health care strategies for reducing incidence of injuries from domestic violence, and cost of injuries to health care facilities. This section is one of the only measures in the VAWA 1994 statute that attempts to address IPV through a health policy framework. The articulated aim

of these studies was to increase public awareness and understanding of IPV to support crafting of more efficient, effective policy under later VAWA reauthorizations. The act authorizes appropriations for these studies.

Beyond this, the Violence Against Women Improvements measures (Title IV, Subtitle E) include congressional mandates to consider survivor health effects in criminal trials against perpetrators of violence. Specifically, Section 40507 leads the Attorney General and the Secretary of HHS to report to specified congressional committees on the “medical and psychological basis of ‘battered women’s syndrome’ and the extent to which evidence of such syndrome has been considered in criminal trials.” Although Section 40507 incorporates the Department of HHS in federal IPV response, these provisions contrast from the ACA’s health policy emphasis by considering IPV’s medical consequences only within the context of abuser sentencing verdicts, rather than in terms of providing aid for survivors. Subtitle F: “National Stalker and Domestic Violence Reduction,” amends the federal judicial code to provide grants to state and local governments for the entering of stalking and domestic violence data into national crime information databases. Section 40609 directs the Attorney General to begin to include data regarding domestic violence as part of the National Incident-Based Reporting System, and to report annually to the Congress concerning stalking and domestic violence. Public health advocates point to the importance of this measure in that, prior to VAWA 1994, lawmakers neglected to research or study IPV; significantly, from this point forward, IPV entered congressional attention when crafting future federal policy.

Finally, VAWA 1994 revised previously existing criminal law, including amendments to the FVPSA requiring grant applications to include a plan to address the needs of underserved populations. Subtitle B, Chapter 7 additionally provides for the suspension of funding for

grantees which fail to submit an annual performance report. VAWA 1994 goes beyond FVPSA to provide technical assistance and training to state domestic violence coalitions to establish special issue resource centers. VAWA 1994 (P.L. 103-322) addresses certain types of violent crime against women through grant programs to State, local, and tribal governments, as well as nonprofit organizations and universities, to reduce domestic violence. VAWA 1994 intended to foster awareness of domestic violence, particularly between intimate partners; the act worked to develop services for survivors, and to revise the manner in which the criminal justice system responds to both domestic violence and sex crimes.

To administer and oversee VAWA 1994 provisions, the Office on Violence Against Women (OVW) was created in 1995 under the Department of Justice. The OVW directs financial and technical assistance to communities nationwide in developing programs, policies, and practices aimed at ending IPV. The OVW administers formula-based and discretionary grant programs established under VAWA, including: (1) Services, Training, Officers, Prosecutors (STOP) grants, (2) Sexual Assault Services Program (SASP) grants, (3) state coalitions, and (4) tribal coalitions. OVW additionally oversees the National Domestic Violence Hotline, the National Sexual Assault Hotline, the National Teen Dating Abuse Helpline, and the National Victim of Crime Hotline to assist survivors in connecting with comprehensive service providers (OVW 2016).

C. VAWA Reauthorizations

I. VAWA 1994 Reauthorizations

Title IV of the Violent Crime Control and Law Enforcement Act of 1994 authorized funding and implementation for VAWA 1994, pending subsequent reauthorization every five fiscal years. VAWA 1994 and its reauthorizations in 2000, 2005, and 2013 are significant in that they represent an evolution in thinking about the crimes that constitute violence against women

and its scope, the impact of violence on different groups of survivors, and how best to address the effects of this violence (Runge et al 2013, 438). As summarized in “Twenty Years of the Violence Against Women Act: Dispatches from the Field,” the general shift over the three iterations of VAWA has been towards:

enhancing services for victims; recognizing sexual assault, dating violence, and stalking as serious crimes that communities are under-resourced to address; and strengthening legal protections and civil remedies for all victims, particularly those for whom accessing safety and justice is harder because of their race, ethnicity, immigration status, age, disability, sexual orientation, or gender identity” (OVW 2016, 1).

This is particularly important to consider in the context of this paper’s analysis of evolving federal health policy regarding IPV, showing the legislative process-tracing from strictly criminal justice services, towards mandates for a broader range of services, culminating in the health policy framework initiated under recent VAWA reauthorizations, and most strongly provided under the ACA.

II. The Violence Against Women and Department of Justice Reauthorization Act of 2005

While Congress reauthorized VAWA in 2000 as part of the Victims of Trafficking and Violence Protection Act of 2000, it was not until the Violence Against Women and Department of Justice Reauthorization Act of 2005 (VAWA 2005) that Congress began to utilize VAWA to contribute to federal health policy combating IPV. Rep. F. James Sensenbrenner (R-WI-5) introduced H.R. 3402, also referred to as the DOJ FY2006-FY2009 Authorization bill, or the Violence Against Women Act Court Training and Improvements Act of 2005, on July 22, 2005. Following its introduction in the House, H.R. 3402 was supported by 19 total cosponsors, including 10 Democrats and nine Republicans. The bill was reported to the House Committee on the Judiciary on September 22, 2005 (H.Rept. 109-233), and passed the House by yeas and nays on September 28, 2005. By December 16, 2005, the Senate Judiciary Committee considered the

reauthorizing legislation, and discharged H.R. 3402 by unanimous consent. The conference committee met on December 17, 2005, to resolve differences in House and Senate bill versions, and the House agreed to a Senate amendment by voice vote (CR H12075-12121).

The 109th Congress passed H.R. 3402 into law by a vote of 415-4 in the House of Representatives, and by unanimous consent in the Senate. President George W. Bush signed H.R. 3402 into law on January 5, 2006, thereby enacting P.L. 109-162. President Bush issued a signing statement on January 10, 2006. However, this presidential message did not explicitly mention the benefits of the VAWA's reauthorization component of the wider bill, but rather singularly focused on wider legislation's provisions enhancing prosecutorial and diplomatic tools to combat international trafficking. Following implementation, VAWA 2005 was accompanied by the enactment of P.L. 109-271, introduced to the 109th Congress by Sen. Arlen Specter (R-PA) as S. 3693 on July 19, 2006. The official title of the bill as introduced in the Senate was a "bill to make technical corrections to the Violence Against Women and Department of Justice Reauthorization Act of 2005." Senator Joseph R. Biden, Jr. cosponsored the bill. Among other things, S. 3693 extended appropriations for certain VAWA 1994 programs, expanded the level of grant funding for community-based programs for survivors of violence, and amended the federal criminal code's definitions of "spouse or intimate partner" to be more widely-encompassing. This "technical corrections" bill passed the Senate without amendment, and by unanimous consent, on July 19, 2006 (CR S7936-7941). The bill passed the House without objection on July 29, 2006, and was signed into law by President Bush on August 12, 2006.

The overall purpose of VAWA 2005 was to amend VAWA 1994 to revise definitions and grant conditions, including new requirements for the protection of the confidentiality and privacy of persons receiving services under the Act. VAWA 2005 appropriated \$3.935 billion over five

fiscal years to continue advancing the goals of 1994, and to tackle issues identified by implementation of VAWA 1994 and VAWA 2000. Under this statute, the 109th Congress extended specific protections for immigrants, children, the elderly, pregnant women, and Native women. The central measures of this reauthorization sought to expand collaboration in preventing, and responding to, violence to include not only law enforcement and emergency crisis services professionals as under previous bill versions, but also health care professionals and youth counselors. VAWA 2005 responded to limitations identified in the original VAWA statutes by improving targeted funding for prevention through targeted programs aiding underserved populations with the greatest risk for violence victimization. In addition, VAWA 2005 focused on funding for survivors facing unique challenges and barrier to health care, such as older survivors, teenagers and college students, and rural and urban communities exhibiting disproportionate rates of victimization (Runge et al 2013, 437).

Title I: “Enhancing Judicial and Law Enforcement Tools to Combat Violence Against Women,” reaffirms VAWA’s guiding emphasis on a criminal justice response to IPV, as the reauthorization places law enforcement methods at the forefront of the legislation. Beginning with Title II: “Improving Services for Victims of Domestic Violence, Dating Violence, Sexual Assault, and Stalking, VAWA 2005 dedicates several provisions to advancing long-term support services for survivors. Section 202 established one example of such services, directing the Attorney General to provide grant funding to states to establish sexual assault services programs, including rape crisis centers and “community-based, culturally-specific intervention and related assistance.” VAWA 2005 also goes beyond previous federal IPV legislation in that it is the first version of VAWA characterized by a stronger emphasis toward violence prevention measures. Title IV: “Strengthening America’s Families by Preventing Violence,” sets up grant funding to

“eligible entities” to mitigate the effects of violence on children and youth, and “to reduce the risk of future victimization or perpetration of such violence” (Sec. 401). Risk reduction and prevention grant funding was therefore directed toward home visitation programs, as well as programs related to engaging men and youth in preventing IPV by “helping them to develop mutually respectful, nonviolent relationships” (Sec. 401). Sec. 403 of Title IV authorizes appropriations for state campaigns to increase public awareness of issues regarding domestic violence and its consequences for pregnant women, in particular.

In examining how the ACA improves upon policies established under VAWA, the most noteworthy provision of VAWA 2005 is Title V: “Strengthening the Healthcare System’s Response to Domestic Violence, Dating Violence, Sexual Assault, and Stalking.” Title V amends the Public Health Service Act to require the Secretary of HHS through the Health Resources and Services Administration (HRSA), to award grants to schools of medicine funding the development of interdisciplinary training and education programs. These programs are designed to provide health professions students with a comprehensive understanding of, and clinical skills relevant to, IPV. Grant funding must be used to: (1) train health professionals to both identify and provide health care services to survivors of violence; and (2) to plan and develop “culturally competent clinical components” to be incorporated into residency training programs, which address health issues related to IPV (Sec. 503). Such training programs exemplify areas in which policymakers incorporated public health best practices for IPV response while crafting ACA legislation. In contrast to VAWA legislation funding, CA funding mandates reflect legislators’ intent to prioritize specialized medical care for survivors, provided by clinicians specifically trained in trauma-informed, sensitive, confidential treatment techniques. Significantly, Section 504 requires the Secretary of HHS and the CDC Director to award grants to state and local

entities to improve the response of health care to IPV victimization through “comprehensive strategies.” Finally, Section 505 authorizes grants to fund research on more effective interventions in the health care setting that: (1) prevent IPV across the lifespan; (2) prevent the long-term health consequences of domestic violence, dating violence, and sexual assault; and (3) advance health and safety of survivors.

D. Legislative History of the Affordable Care Act (ACA) (2010)

Following VAWA 2005, the ACA was the first piece of major federal legislation containing sections offering targeted solutions to IPV survivors’ needs. Lawmakers and the Obama administration presented the ACA as a drastic overhaul of federal health policy, and the U.S. health insurance and health care systems. Understanding the contextual information described in the ACA’s legislative history, such as insight into policymakers’ intent in crafting the ACA’s policies, will facilitate deeper evaluation of whether the ACA’s provisions present more effective services for survivors, beyond the services initially offered by VAWA.

I. Bill Information and Timeline of Action on the Bill

On September 17, 2009, Rep. Charles B. Rangel (D-NY-15) introduced H.R. 3590,⁶ Patient Protection and Affordable Care Act. 40 legislators cosponsored this bill under the 111th Congress, including 37 Democrats and 3 Republicans. The official title of the bill, as introduced in the House, was: to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the care of members of the Armed Forces and certain other Federal employees, and for other purposes. The short title, as introduced in the House, was: the Service Members Home Ownership Tax Act of 2009. This title evolved to the Patient Protection and Affordable Care Act, Service Members Home Ownership Tax Act of 2009 by the time of

⁶ H.R. 4872 also made a number of health-related financing and revenue changes. Read together, H.R. 3590 and the health care-related provisions of H.R. 4872 are commonly referred to as the Affordable Care Act (ACA).

passage in the House of Representatives. In the Senate, the bill that became the ACA was officially entitled The Patient Protection and Affordable Care Act. During the time of its drafting and consideration, however, H.R. 3590 was popularly referred to simply as the “health care reform bill” (CRS 2010). Over 15 related bills accompanied the health care reform bill, including eight bills introduced in the House of Representatives to address more specific health or tax credit needs, and seven similar bills introduced in the Senate.

Following its introduction in the House of Representatives, lawmakers added 506 amendments to the bill during the course of congressional hearings, committee consideration, and floor debate. H.R. 3590 was referred to several committees for more detailed consideration, including: the House Committee on Health, Education, Labor, and Pensions (HELP Committee); the House Committee on Energy and Commerce, Subcommittee on Health; the House Committee on Ways and Means, Subcommittee on Health; and the Senate Finance Committee. After being reported out of committee, H.R. 3590 was voted on in the House on October 8, 2009 on motion to suspend the rules and pass the bill, agreed by the yeas and nays 416-0 (CR 10/07/2009 H10550). 16 Members did not vote. The Senate later considered the health care reform bill, voting on December 24, 2009 to pass the bill, with amendments, by a yea-nay vote of 60-39. Included in the yea votes were 58 Democratic Senators and two Independents; Republican Senators cast all 39 of the nay votes (CR S13890-14212).

In March of 2010, a conference committee met to resolve differences between the House and Senate versions of the health care reform bill. The House agreed to Senate amendments to H.R. 3590 on March 21, 2010, by a recorded vote of 219-212 (Roll no. 165), with the majority of yea votes cast by Democrats, and most nay votes cast by Republican Members. The Patient

Protection and Affordable Care Act (ACA) was presented to the President on March 22, 2010. President Obama signed the ACA into law (P.L. 111-148) on March 23, 2010.

II. Committee Hearings and Reports

In two years prior to the ACA's enactment in 2010, policymakers proposed and considered several iterations of the bill that eventually passed into law. During this period, congressional committees, particularly the HELP Committee and the Committee on Ways and Means, conducted hundreds of hearings to inform drafting. In the context of this work, one committee report essential to understanding the ACA's health policy goals is entitled "Affordable Health Care for America Act: Meeting Women's Health Care Needs." The House Committees on Ways and Means, Energy and Commerce, and Education and Labor issued this report on October 29, 2009. It is important to note that this committee report references a previous version of H.R. 3590, introduced in the prior congressional session under the title Affordable Health Care for America Act. I single out this committee report for more detailed analysis in that it illuminates the evolution of health care reform bills under the 111th Congress, as well as elucidates lawmakers' intent and thought-processes in crafting the ACA statute.

The report "Meeting Women's Health Care Needs" acknowledged that under the health care system in place prior to the ACA, comprehensive health care for women, in general, as often unavailable, prohibitively expensive, or excluded key services that women need. These effects were exacerbated for women who are also survivors of violence. Because of this, the committees proposed several key women's health provisions for incorporation in health care reform. Even in crafting this early form of the eventual ACA statute, lawmakers recognized need to "immediately prohibit plans from discriminating on the basis of domestic violence as a pre-existing condition" (1). In addition, the report advocates for maternity and prevention services in any essential health benefits package, and to make preventive care more affordable by

eliminating out-of-pocket expenses on recommended preventive services. These “recommended preventive services” included IPV screenings (“Meeting Women’s Health Care Needs 1). This committee report therefore directly relates to my guiding research question, in exemplifying how IPV was considered throughout the ACA’s drafting and evolution.

IV. Presidential Message

Upon signing the ACA into law on March 23, 2010, President Obama issued a signing statement remarks, emphasizing that the legislation sets in motion “reforms that generations of Americans have fought for and marched for and hungered to see” (American Presidency Project 2010). In particular, the president’s highlighted the ACA’s coverage extensions for Americans with preexisting conditions, requirements for free preventive care, and creation of health insurance exchanges increasing widespread access to affordable, quality insurance. President Obama’s remarks also thanked the tireless efforts of Speaker of the House Nancy Pelosi, Senate Majority Leader Harry Reid, Secretary of HHS Kathleen Sebelius, White House official Nancy-Ann DeParle, and the numerous advocates who fought to make the legislative vision of equitable health care into reality. President Obama lauded the ACA for enshrining “the core principle that everybody should have some basic security when it comes to their health care,” and for extending protections to populations with heightened health risks (American Presidency Project, 2010). Although President Obama did not overtly reference the ACA’s beneficial impact on IPV survivors, the weight placed on accessibility and prevention in this signing statement indicates the Obama administration’s emphasis on sections of the legislation most impactful for IPV survivors.

In addition, immediately after President Obama signed the ACA into law, Former White House Advisor on Violence Against Women, Lynn Rosenthal, published a post reflecting the White House’s position on the new legislation. Entitled, “For Victims of Domestic Violence,

Health Care is a Lifeline,” Rosenthal articulated one of the central aims of the federal government in passing the ACA: to “help domestic violence victims get the health care they need.” This published post is one of the earliest official government publications recognizing the impact of the ACA on IPV survivor health, noting, “For all women, the advent of health care reform is a victory. For domestic violence victims, it is a lifeline” (Rosenthal 2010). By discussing the ACA’s importance in ensuring that survivors do not have to worry about access to care, this post implicitly acknowledges the shortcomings of existing VAWA legislation, and highlights the necessity for a greater, intentional focus on women, and IPV survivors in particular, in drafting any health care reform policy. Rosenthal’s post is significant in understanding the position of the Obama administration in advocating for this legislation, and particularly in highlighting the emphasis placed specifically on expanding access to comprehensive care for IPV survivors, beyond the care provided under existing federal IPV policy. Rosenthal’s statement therefore further reiterates the congressional and White House intent in drafting the ACA, and in including provisions targeting IPV through service and funding mandates.

VI. Summary of Public Law 111-148

As the ACA sparked an extremely vast, wide-ranging reform of the entire U.S. health care system and health insurance markets, an overview summarizing the entirety of the ACA’s provisions is far beyond the scope of this paper. As explained in the Research Design, I primarily examine the ACA in comparison to the baseline provisions established under VAWA, therefore this summary narrows in on the portions of the ACA statute most pertinent to women’s health care and, more specifically, service and funding mandates for IPV survivors. The described relevant sections were identified as explained in the Research Design. As I subsequently focus

on the case study of services available to survivors at CHC sites, this summary additionally explicates sections of the ACA establishing grant funding for these CHCs.

The overall aim of the ACA, as expressed in Title I: “Quality, Affordable Health Care for All Americans,” was to introduce new regulations for the insurance industry to facilitate access to insurance coverage, and to prevent insurance discrimination. The ACA was specifically designed to address disparities in access to quality health care services (Atsas and Kunz 2014, 409). In this way, the ACA has the potential to prove critically impactful for IPV survivors by increasing the number of survivors with insurance coverage, increasing the value of insurance coverage for addressing IPV-related health effects and reproductive health, as well as facilitating access to reproductive health services (Sonfield et al 2013). By drastically expanding the ability to purchase insurance, the ACA permits countless survivors to gain entry into a health system previously barred to them; this is an extremely important point in that the health care system serves as the entry point for many survivors in reporting violence and accessing care (Stolp and Fox 2015, 878).

Title I, Subtitle A “Immediate health Improvements in Health Care Coverage for All Americans” signifies a major reform in federal health policy by requiring health plans to provide coverage, without cost-sharing, for: (1) general preventive services; (2) recommended immunizations; and (3) recommended preventive care and screenings for women and children. While previous health policy, in addition to federal IPV policy, were based on more reactionary measures to health issues, this emphasis on preventive services in the opening section of the ACA highlights the centrality of prevention and risk reduction under the reform legislation. As expressed by Futures Without Violence, the ACA’s mandates promoting preventive care reflect the goal of “injury and violence free living” as one of the seven national health policy priorities

implemented under the ACA's reforms (2012, 3). For the first time, policymakers included violence prevention, including IPV risk reduction, as a central aim of health legislation.

Title I additionally establishes access to quality health insurance coverage for all Americans through health insurance market reforms, and establishment of quality health plans. Subtitle C, Part I, prohibits health plans from imposing any preexisting condition exclusion, or from discriminating on the basis of any health status-related factor (Section 1201). Section 1201's health insurance market reforms thus prove crucial to expanding IPV survivor's access to care, as insurance plans can no longer deny survivors,⁷ or charge higher premium rates, based upon previous exposure to violence. Most notably, Subtitle D "Available Coverage Choices for All Americans" created requirements for health plans to cover "essential health benefits" (Section 1302). The ACA defines these essential health benefits (EHBs) to include "emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, preventive and wellness services and chronic disease management, and pediatric services" (Section 1302). The act directs the newly established U.S. Preventive Services Task Force (USPSTF) (Section 4104) to study and recommend a list of comprehensive "preventive and wellness services" for inclusion under these EHBs. Following this mandate upon ACA implementation, the USPSTF made recommendations for preventive services based on criteria including: (1) that the service's targeted condition affects a broad population, (2) scientific evidence supports the recommendation, and (3) the advocated intervention has potential to improve health or well-being "significantly" (Stolp and Fox 2015). As a result, the USPSTF advised coverage of: vaccinations; interventions to facilitate breastfeeding; screenings for STIs, and for certain cancers; preventive care for minors, including counseling and

⁷ Prior to the enactment of Section 1201 of the ACA, domestic violence and sexual assault survivors could be denied health insurance, as violence victimization could be considered a "pre-existing condition." As a result, over 65 million women were denied insurance coverage prior to 2010 (Nicelli 2017, 3).

reproductive health issues; annual well-woman visits; expanded services for pregnant women; and, most critical to the focus of this legislative analysis, screening and counseling for IPV (Sonfield et al 2013; U.S.C. 42 U.S.C. 18001). In this way, the ACA vastly advances the definition of basic health care to provide for coverage of key services for women, and for violence prevention.

The ACA also prioritizes women's health care and prevention services through Title III: "Improving the Quality and Efficiency of Health Care." For example, Subtitle C requires Medicare Advantage plans to apply the full amount of rebates, bonuses, and supplemental premiums for reduction of cost sharing, and for coverage of preventive care and wellness benefits (Section 3202). Subtitle F: "Health Care Quality Improvements" specifically establishes an Office on Women's Health within the Office of the Secretary, the Office of the Director of the CDC, the Office of the AHRQ Direction, the Office of the Administrator of the HRSA, and the Office of the Commissioner of Food and Drugs (Section 3509). The Act also authorized appropriations for all such Offices on Women's Health for FY 2010-FY2014. The ACA creates each of these respective offices to provide for a designated office specifically enforcing the ACA's provisions under the framework of providing services for underserved, at-risk women.

Building upon these measures, Title IV centers on "Prevention of Chronic Disease and Improving Public Health." In particular, Subtitle A: "Modernizing Disease Prevention and Public Health Systems" exemplifies areas in which the ACA goes beyond prior health policy mandates to institute prevention, including violence prevention, as the principal national health care strategy. Subtitle A requires the President to: (1) establish the National Prevention, Health Promotion and Public Health Council; (2) create the Advisory Group on Prevention, Health Promotion, and Integrative Public Health; and (3) appoint the Surgeon General as Chairperson of

the Council in order to develop a national prevention, health promotion, and public health strategy (Section 4001). The ACA mandates funding for preventive care through the formation of a Prevention and Public Health Fund (Section 4002). Plus, Section 4003 compels the Director of the CDC to convene an independent Community Preventive Services Task Force to review scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community prevention intervention, purposed to develop recommendations for policymakers. Related to this measure, Title IV, Subtitle B “Increasing Access to Clinical Preventive Services” amends the Social Security Act Title XVII⁸ to provide coverage of personalized prevention plan services for individuals, and prohibits cost-sharing of such services (Sections 4103-4104). These measures are significant to my overall research question in that they represent major distinctions, and expansions, from VAWA legislation’s treatment of IPV survivors. Title IV provisions demonstrate the ways in which federal IPV response evolved from reactionary efforts that largely neglected IPV’s health consequences, towards a more preventive focus aimed at reducing IPV and devastating personal and public health impact.

In order to implement the listed preventive care measures, Title IV, Subtitle C: “Creating Healthier Communities” mandates grant funding to state and local agencies, and community-based organizations, for implementation and dissemination of “evidence-based community preventive health activities” (Section 4201). Plus, of particular importance to this study’s focus on IPV survivors, Subtitle C, Section 4206 establishes a “pilot program” to test the impact of providing individualized wellness and prevention plans to at-risk populations who utilize CHCs. The aim of such wellness plans is to reduce risk factors for preventable conditions, including IPV and its detrimental health effects, as identified by a comprehensive risk-factor assessment. In

⁸ This title establishes the program commonly referred to as Medicare.

support of prevention and wellness plans, Subtitle D: “Support for Prevention and Public Health Innovation,” provides funding for federally conducted research regarding health disparities within at-risk and medically underserved populations (Section 4302).

The ACA supports underserved populations, including IPV survivors, through funding both for training of health care professionals, as well as for CHCs. For instance, Title V, Subtitle D: “Enhancing Health Care Workforce Education and Training” awards grants to promote positive health behaviors and outcomes for populations in medically underserved communities, using community health workers (Section 5313). Title V provides supports for the existing health care workforce through grants to educate primary care providers about preventive medicine, chronic disease and violence reduction management, and mental and behavioral health services (Section 5405). Subtitle D thus considerably contributes to the ACA’s advancement of services for survivors, in that such training grants recognize and encompass the necessity of health provider trainings in meeting the definition of truly “comprehensive services” established in the Literature Review and Research Design. Plus, of extreme importance to my case study regarding services accessible at CHCs, Subtitle G: “Improving Access to Health Care Services” centers on authorizing appropriations for health centers to service medically underserved populations (Section 5601). Coupled with Title X, Section 103333, this section amends the Public Health Service Act to authorize grants to support community-based collaborative care networks for low-income populations. Lastly, Title X, Subtitle E, Section 10503 establishes a Community Health Center Fund to provide for sustained national investment in CHCs, and prioritization of the health needs of populations utilizing CHC services.

Discussion and Analysis: Comparing VAWA and the ACA

Both drafted to address needs of underserved and vulnerable populations, VAWA and the ACA drastically differ in their primary goals, and the lens applied to IPV survivors and

victimization. Though VAWA legislation effectively introduced IPV into the realm of public attention and national policy priorities, it falls short in very narrowly addressing survivors' needs. With IPV generating a huge national health crisis, representing the most common cause of injury for American women, this violence must be prioritized in federal health policy. To answer my central research question concerning the extent to which the ACA improves health services for survivors beyond prior legislation, it is imperative to analyze the ACA's provisions in relation to VAWA's service and funding mandates.

A. Limitations of VAWA

Arguably, the VAWA statutes fostered greater awareness and recognition of IPV as a national public health issue, and took key steps towards protecting the safety and health of survivors. Largely as a result of VAWA's provisions, the rate of IPV against female survivors declined 53 percent between 1993 and 2008, from 9.4 victimizations per 1,000 females over 12 years of age, to an average of 4.3 victimizations per 1,000 females (Modi et al 2013). According to the Bureau of Justice Statistics, the rates of violence against males also declined by 54 percent during this period. Plus, a University of Kentucky report showed a 51 percent increase in reporting after the passage of VAWA, an over 60 percent decrease in nonfatal violence, and a 24 percent decrease in fatal IPV (Modi et al 254). The Office on Violence Against Women (OVW), created under the Department of Justice to administer VAWA provisions, also issued a 2016 report analyzing the improvements in federal IPV policy implemented in the period since VAWA's implementation. OVW noted the greater coordination among systems and collaboration across disciplines; maximization of the limited funding available for core victim services like housing and legal assistance; combatting misinformation, bias, and victim-blaming attitudes in both public and lawmakers' understanding of IPV; and enactment of trauma-

informed service models and trainings (OVW 2016, 16).

Despite these important improvements, by the time of the ACA's drafting in 2010, IPV remained an extremely prevalent public health issue; the 2010 National Intimate Partner and Sexual Violence Survey reported between 1.3 and 5.3 million U.S. women experience physical violence, sexual violence, or psychological aggression each year (Modi et al 253). Each subsequent reauthorization of VAWA expanded the definition of violence addressed, as well as the scope of protections extended to survivors, yet public health scholars and healthcare professionals identified several areas of greater need. Prior to the ACA's drafting, however, few scholars examined VAWA's shortcomings, or the need for additional federal legislation targeting IPV's health consequences, in a truly comprehensive manner. VAWA fell short in creating systems-level change, and "potentially one of the largest shortcomings of VAWA is the lack of any comprehensive evaluation of the legislation," resulting in "complacency, as opposed to continued reform" (Aday 2015, 19). In contrast to the ACA, which predominantly addresses survivors' needs through promoting accessibility of health care and insurance coverage, VAWA 1994 most directly aided survivors by offering solutions to short-term, crisis-based interventions, as well as housing needs. As articulated by Runge et al, funding for emergency shelters for "battered women" formed "the backbone of the service provider community for victims at the time" of VAWA's passage (445). However, VAWA's shelter funding provided only a temporary solution to the instability and health consequences inflicted by IPV; this funding proved insufficient in promoting long-term safety, stability, and therefore positive health outcomes for survivors.

Through examining VAWA's legislative history, coupled with academic and government analyses of the legislation's mission and goals, it becomes clear that federal response to IPV

slowly progressed from addressing solely the immediate legal needs of survivors, towards meeting the long-term needs to empower survivors to live free from violence (Runge et al 2013, 456). Despite this evolution, several vital provisions were excluded from both the VAWA 1994 statute, as well as its subsequent reauthorizations. For example, noticeably absent from VAWA legislation are economic remedies for survivors, including access to housing, employment, and insurance protections (Runge et al 2013, 453). While VAWA 2000 did authorize a study on health insurance discrimination against survivors, subsequent reauthorizations of the statute failed to include strong protections for health care services or antidiscrimination in insurance coverage. In fact, during the legislative sessions in which VAWA 2000 and 2005 were considered, provisions for such measures constituted part of early drafts or were introduced as part of the original bill, but were left out of the final versions that passed. In spite of such efforts to increase the economic and health care focus of federal IPV response, it was not until the ACA's passage that federal legislation officially included provisions directly addressing survivors' complex health needs. Plus, VAWA insufficiently provides for specialized training for many officials tasked with promoting the long-term safety and security of IPV survivors. For example, VAWA training funds are predominantly allocated to law enforcement officers and exclude countless other officials that may interact with survivors. Beyond this, funds are limited in providing only for one-time, ad hoc trainings that largely fail to establish a trauma-sensitive care protocol. Several studies note that gaps in service often arise because officials lack the expertise to efficiently and effectively deliver a given service mandated under VAWA, as it relates to IPV or gender-based violence (2015, 15).

Through its 2016 study on the VAWA's effectiveness in the 20 years following its enactment, OVW identified key areas of potential improvement to VAWA legislation to enhance

services provided beyond the criminal justice response. Alarming, none of VAWA's reauthorizations fully provided for the basic needs of all survivors for "food, shelter, health, and safety" (OVW 2016, 16). Plus, OVW's report highlights VAWA's inability to address the intersections among complex trauma, multiple victimizations, mental health and substance abuse, and poverty common among IPV survivors. OVW elucidates one of the most significant shortcomings of VAWA by arguing for a refocus of federal policy towards preventing violence, not just through risk reduction as under VAWA's reauthorizations, but through eliminating its root causes. Lastly, to improve federal IPV response beyond VAWA provisions, the OVW report encouraged policies to help survivors pursue alternative paths to safety, other than the criminal justice system and shelter services (16). Lawmakers worked to address a myriad of these limitations, particularly through funding for more comprehensive services, in formulating health care reform policy under the ACA.

B. Distinctions Between VAWA and the ACA's Approach to IPV Survivors

VAWA and the ACA are comparable in their treatment of IPV only in the sense that both pieces of legislation primarily approach survivors' needs through grant funding to public or private community-based programs, as opposed to through direct provision of services (Aday 2015, 6). During the drafting of the ACA, the advocacy of IPV survivors and public health scholars elucidated to lawmakers the detriments of VAWA's narrow criminal justice focus, and the lack of emphasis on violence prevention. Problematically, VAWA legislation does not specifically target funds to areas with the greatest need, such as communities with the highest rates of IPV victimization (Tielfenthaler et al 2005, 566). Even after the federal government became more directly involved in the funding of programs to assist IPV survivors via VAWA, existing agencies expanded their offerings, but the number of programs did not increase

significantly. In this way, VAWA did not go far enough in expanding access to services, as shown by the mere two percent increase in available programs between the 1994 passage and the 2000 reauthorization of VAWA funding (Tielfenthaler et al 2005, 576).

In evaluating VAWA's success towards mitigating IPV and its effects on survivors, scholars agree that one of the greatest advantages of the Act is its promotion of partnerships between sectors. For example, the long-term goal of the STOP grant program is to "promote institutionalized system change through communities that results in supportive and effective responses from the criminal justice and civil justice systems, and other community agencies such as domestic violence and sexual assault programs (Aday 2015, 13). Public health studies suggest that the institutionalization of efforts for a community-coordinated response has led to a decrease in total victimization, and a decrease in repeat offenders. Under VAWA, not only are law enforcement agencies better equipped to prosecute offenders, but survivors are also empowered and supported through social service agencies and domestic violence shelters, thereby decreasing the likelihood that survivors will return to violent partners. While this marks a success for VAWA in efforts to reach its overarching goals, this example also shows the fundamental importance of implementing not just a criminal justice response to violence, but also a comprehensive, community-centered response. Analyzing the effectiveness of community-coordinated responses to violence highlights the need for, and advantages of, a heightened social service and health care response to violence. While VAWA falls short in meeting this need, the ACA is explicitly purposed at implementing a health care response.

As a result of VAWA's identified shortcomings, the ACA's legislative history reveals how lawmakers sought to make IPV a greater priority in federal health policy reform. In contrast to VAWA's approach, the two primary methods through which the ACA affects IPV survivors

include: (1) supporting routine screening and counseling for IPV, including at primary care and annual well-woman visits; and (2) inclusion of domestic violence in the National Prevention Strategy (Futures Without Violence 2012, 3). This is distinctive from the driving mission, goals, and methods of the VAWA legislation in its support for IPV survivors. While VAWA is administered by the OVW under the Department of Justice, thereby reiterating the central law enforcement response under VAWA, policy under ACA markedly differs in that the HRSA, the CDC, and the Secretary of HHS oversee its implementation. This is a notable distinction in that the agencies administering each law serve as key indicators of the central purposes of the law's provisions, as revealed by the lens with which experts in each respective agency view, and tackle, IPV.

As explained by Futures Without Violence (2012), the “Congressional intent under the ACA was that screening and assessing for domestic violence can be considered a primary prevention or early intervention service, similar to obesity screening, smoking cessation, and alcohol misuse, which is already covered by providers” (1). Overall, the principles through which the ACA views, and treats, IPV survivors vary greatly from the guiding intent of VAWA in a manner that supports survivor short-term and long-term health. The ACA’s “lasting impact is its attempt to move the health system from a disease treatment model to prevention and health promotion” (Futures Without Violence 2012, 3). One provision central to this aim is the ACA’s support for services, and funding mandates, for CHCs.

Discussion and Analysis: Examining the Case Study of CHCs under the ACA

A. CHC Funding under the ACA

As previously explained in the Literature Review and Research Design sections, CHCs represent sites in which the ACA has the opportunity to be particularly and immediately

impactful in promoting services, and positive health outcomes, for IPV survivors. While the ACA insurance coverage expansions independently represent a significant step towards improving accessibility of health care services, “increased coverage may be of limited benefit if there are not enough places where patients can obtain care” (Han et al 2017). Therefore, CHCs “play a key role in implementation of the Affordable Care Act” (HRSA 2012, 1) by acting as the predominant sites through which newly-insured Americans can access health services.

CHCs have a long history of supporting health outcomes of Americans facing the greatest levels of need. The first CHC opened in 1965 under the direction of the Office of Economic Opportunity, as a major component of President Lyndon B. Johnson’s War on Poverty initiative (Adashi et al). CHCs were founded on the guiding mission of reducing or eliminating health disparities that affected racial and ethnic minority groups, the poor, and the uninsured. The health center model that emerged, as advocated for by community health and civil rights activists, targeted the roots of poverty by combining the resources of local communities with federal funds to establish neighborhood clinics (“About Our Health Centers”). As of 2015, CHCs served one in three minority patients who fell below the federal poverty line, and one in seven of all US rural residents; these are the proximate patients most disadvantaged, and most lacking IPV treatment methods (Proser et al 2015, 50). The CHC model also overcomes geographic, cultural, linguistic, and other barriers through a collaborative-based approach to care. This team-based system includes physicians, nurses, dental providers, midwives, behavioral health care providers, social workers, health educators, and many others (HRSA 2012, 2). In this way, CHCs were designed to constitute a key component of the federal public safety net.

CHCs recognize, and build upon, the link between multidisciplinary healthcare teams and improved patient outcomes, reduced disparities, and lower costs. It is widely recognized by

public health and IPV advocates that the unique model of care delivery through CHCs uses multiple primary team members with varied skills to increase capacity, reduce barriers to care, and even control the costs of care (Proser et al 2015, 49). In fact, CHCs save the healthcare system an average of \$24 billion annually by reducing the use of emergency departments and inpatient care for preventable conditions, including many of the long-term side effects of IPV.

While CHCs were well established prior to the ACA, the ACA significantly augmented health center funding. The ACA, as passed in 2010, established the Community Health Center Fund, providing a total of \$11 billion in federal funding over a five-year period for “operation, expansion, and construction of health centers throughout the nation” (HRSA 2012). This funding included \$9.5 billion to support ongoing health center operations, to create new CHCs in medically underserved areas, and--most relevant to the focus of this paper--to expand preventive and primary health care services at existing sites. Federal grant funding is essential to support health centers; as of 2015, these grants provided close to 20 percent of health center revenues (Paradise et al 2017). The Medicare Access and CHIP Reauthorization Act of 2015 further expanded this funding for 2016 and 2017 (Han et al 2017, 49). This two year extension of critical mandatory funding for CHCs, as well as for the National Health Service Corps, stabilized federal funding. In total, over 70 percent of federal health center funding is provided by the health center trust fund set up by the ACA; without the ACA, federal funding for CHCs would be deficient (Paradise et al 2017).

B. Impact of ACA Funding for CHCs: Growth in CHC Capacity, Utilization, and Funding for “Comprehensive Services”

Recent research indicates that CHCs are characterized as particularly responsive during periods of insurance expansion, such as during Medicaid expansion and the ACA implementation period. This becomes clearly evident when examining the ACA expansion’s

effects on CHC capacity and utilization. Notably, every additional million dollars in federal grants for CHCs is associated with capacity to serve about 8,000 more patients per center (Han et al 2017, 53). As a result, CHC capacity drastically increased in the period following ACA implementation. While CHCs served approximately 19.5 million patients in 2010, prior to the ACA's provisions taking effect, these centers provided care for over 24 million patients. (NPR 2015). This represents about one in 12 U.S. residents; nearly 60 percent of those treated at CHCs were women, particularly women with high likelihood of exposure to violence (Paradise et al 2017). The ACA underwrites CHCs, and was predicted to enable the centers to serve nearly 20 million new patients, and to add 15,000 providers to staffs, by the year 2015 (Adashi et al). As of 2014, it was predicted that the ACA's coverage expansions and grants will allow CHCs to serve a total of approximately 40 million patients between 2010 and 2019 (Atsas and Kunz 2014, 417). As of 2017, CHCs serve as the primary medical service provider for over 27 million people in over 10,400 rural and urban communities across the United States.

Increased CHC capacity, and subsequently heightened CHC service utilization, are directly linked to improved connections to care for IPV survivors. By helping survivors to afford services, and by expanding the ability of CHCs to provide additional services, the ACA opens a channel of communication, and potential intervention, between patients experiencing violence and their health care providers. This marks a significant step in IPV prevention and intervention; women who have the opportunity to speak with a healthcare provider about abuse are four times more likely to use intervention, and are over two and a half times more likely to exit an abusive relationship (Paradise et al 2017, 34). Access to greater intervention in this manner makes a huge impact on survivors' health outcomes.

Interviews with clinic directors, IPV advocates, and CHC staff emphasize that the ACA

has been a “game changer” for clinics, particularly in that CHCs can receive reimbursement for much more of the care provided to patients. The health center patient population is increasingly insured, with 76 percent of patients insured by 2015, compared to 65 percent in 2013. This increase in coverage directly coincided with implementation of ACA service expansions beginning on January 1, 2014 (Futures Without Violence 2017, 3).

CHC expansion directly relies on having reliable, long-term revenue; the Community Health Center Fund established under the ACA is what provides this vital funding source. CHCs’ total revenues grew from \$15.9 billion in 2013, to over \$21 billion by 2015 due to increases in patient revenues and federal funding under the ACA’s bolstering of Section 330 grants. The necessity of CHC funding via ACA provisions, and the potential detriment to survivors’ health in the case of an ACA repeal measure, becomes apparent in examining the effects of temporary lapse in CHC federal funds in the fall of 2017. The ACA’s Community Health Center Fund expired on September 30, 2017, and funding provisions were not renewed until February 2, 2018. During this period of lapsed revenue, CHCs’ ability to offer vital services to IPV survivors, and to all patients, was considerably diminished. The Kaiser Family Foundation surveyed health centers amidst the fall funding deficiencies, revealing that without grants secured under the ACA, CHCs reported a marked disruption in care provided. For example, two-thirds of CHCs reported instituting a hiring freeze, and 57 percent said they would need to lay off staff in the absence of federal funding for service mandates. In addition, 60 percent of CHCs surveyed reported cancelling or delaying new projects and investments, such as building expansions and advanced training for staff. Finally, nearly 40 percent of CHCs included in the study said that they were considering severely reducing, and even eliminating, mental health services offered.

This is extremely detrimental to both the short-term and long-term health outcomes of IPV survivors, in that survivors still face continued exposure to violence, and repeated victimization, even in the absence of support services that work to mitigate the impact of such violence. Plus, the care disruptions and cutbacks reported by CHCs as a result of the lapse in federal funding effectively cancel out the positive impact of the exact services that the ACA implemented or expanded. The negative consequences of this funding lapse further support the point that support the ACA's funding for CHCs is foundational to accessibility of services for IPV survivors; when CHCs face decreased funding, and therefore decreased capacity, the very services most in need for survivors are those that are likely eliminated first.

Plus, academic and nonprofit-based studies reveal that investment made in health centers clearly translated to an increase in the types of services available to patients. Han et al (2017) found that mental health services are particularly responsive to increases in federal grant dollars. This is extremely significant for IPV survivors in promoting availability of the very services most necessary for long-term positive health, yet the least available and funded prior to the ACA's provisions. Federal funding grants enable CHCs to finance care for uninsured patients, subsidize insured patients, and finance services not covered by insurance. For example, ACA Section 330 grant funding enables services not covered by most basic insurance plans, including adult dental, transportation to care providers, and translation services. In addition, grant funding expands CHCs' capacity for care management, and even to use sliding fees for privately insured patients who cannot afford deductibles and copays (Paradise et al 2017, 6). IPV survivors depend upon these program and funding mandates in that survivors are often burdened with high health care costs, and with several co-occurring health issues perpetuated by violence victimization. Plus, IPV survivors are at risk for repeated future victimization in that many are

financially dependent on their intimate partners, and cannot afford to separate from their partners, or to seek treatment, in the absence of CHC grant funding. The Kaiser Family Foundation report explicitly argues that the “significant improvement in the ability of uninsured patients to access medical care may be the result of efforts by health centers to expand their capacity with funding made available by the ACA” (Kaiser Family Foundation 2018).

Grant funding for CHCs under the ACA has additionally proved impactful for IPV survivors in expand the types of comprehensive services offered to survivors at CHCs, namely mental health services. In 2016, the Kaiser Family Foundation reported over 104 million patient visits to CHCs. Of these visits, 68 percent were medical care visits, and nearly 10 percent were mental health and substance abuse disorder services. Also important to note was the fact that six percent of visits resulted in assistance to enable access to other necessary care services beyond those available through the particular CHC, itself (Kaiser Family Foundation 2018). Most significantly, the report “Community Health Centers: Growing Importance in a Changing Health Care System” describes changes in CHC services available between 2010, prior to ACA implementation, and 2016.

One of the most necessary, but often under-provided, services for IPV survivors is mental health treatment; the ACA works to recognize mental health treatment as of equal necessity with emergency services or primary care, particularly when treating IPC survivors who may experience mental health issues like PTSD. While only 73 percent of CHCs offered mental health care services prior to the ACA, this number rose to 87 percent by 2016. This substantial increase in mental health service availability exemplifies the ACA’s positive impact on CHC capacity for “comprehensive services,” and promotes mental health care as a standard form of care. Similarly, in 2010 only one-fifth of CHCs offered substance abuse disorder services, while

by 2016 nearly 30 percent of health centers employ dedicated staff for disorder treatment. Neither of these forms of services was accessible, or even offered, for survivors under the provisions constituting services for survivors under VAWA.

Conclusion

A. Summary, Discussion, and Conclusions

Attempts to update, and improve upon, federal health policy for IPV must be evaluated based on the extent to which they provide institutionalized support to promote access to care not just in theory, but in practice. Through this detailed examination of the legislative histories and policy outcomes of both VAWA and the ACA, I aimed to analyze the degree to which the ACA met this standard, and improved upon VAWA provisions for IPV survivors. My findings support public health scholars' claims that the ACA does improve upon VAWA's policies in its shift from the criminal justice and law enforcement response, to identifying the health care needs to survivors. The ACA is particularly impactful in shifting emphasis from reactionary legal measures to preventive health care efforts, and in ensuring that survivors have access to preventive screenings, emergency, services, primary care, and other comprehensive services through a network of CHCs. Not only does the ACA provide mandates for key survivor services, but accounts for funding of these provisions, as well. I conclude that the ACA legislative does have a positive impact on health care service accessibility for survivors. While the ACA represents a monumental step forward for survivor health, it does so in a manner that excludes explicit mentions of IPV, thereby straying from VAWA's main goals to instead address underserved health needs, more generally. Future legislation can further improve upon the federal IPV response by incorporating VAWA's exclusive targeting of IPV with ACA's central focus on health care and prevention.

B. Limitations and Directions for Future Study

My findings and conclusions in this study are limited in the sense that I rely largely on qualitative, secondary data. In using data collected by others, particularly by IPV advocacy organizations and nonprofit groups like the Kaiser Family Foundation, my analysis is at greater risk for the influence of normative bias. For example, while nonpartisan government officials collect data sourced from the CRS and CBO, the data, analysis, and reports provided by non-governmental sources may contain a partisan or ideology-based lens. My data and conclusions are also limited in the fact that, as this study was the first attempt to comprehensively analyze the ACA's impact specifically on IPV survivors, there are very few quantitative studies detailing service availability, funding, and utilization before and after ACA implementation. Plus, even when studies of CHC service utilization are available, they do not report specifically on increases in service utilization by IPV survivors, but by the entire population of people seeking care at CHCs. As a result, it cannot be fully determined whether the ACA has causally increased use of comprehensive services by survivors. Services offered via CHC sites, and overall CHC capacity, vary greatly by state under the ACA, as state-level discretion in implementing the ACA's Medicaid expansion produces widespread disparities in the legislation's funding levels. A more detailed analysis of services for survivors in states that expanded Medicaid, as compared to states that did not expand Medicaid, was not included in the scope of this paper. Finally, as explicated in the Research Design section, my data is also limited in that, as the ACA only began full implementation in 2014, its long-term impact on health outcomes cannot yet be determined.

In light of these limitations, a central question for future research will be the extent to which IPV survivor positive health outcomes, including mental health and violence prevention, are causally related to ACA provisions. While the ACA promotes prevention, primarily through

preventive screenings, future studies must also examine the effectiveness of post-screening interventions. For example, one possible future research question is: to what extent are preventive screenings related to reduction in violence victimization, connection to the services most necessary for survivors, and improvement in survivor health? Lastly, this study very narrowly examined ACA provisions in comparison to VAWA, and through the lens of IPV survivor health care. As the ACA produced such sweeping reforms to all sectors of the U.S. health care systems and health insurance markets, future studies must go further in examining the full scope of ACA provisions impacting survivors, beyond this study's limited focus on CHCs.

C. Implications and Future Policy Recommendations

In examining the legislative histories, policy provisions, and implementation effects of the ACA in comparison to VAWA legislation, it becomes clear that the ACA provides a more comprehensive, proactive response to IPV than previous legislative efforts. While the ACA implemented significant supports for survivors, several persistent challenges point to key areas for reform and improvement. Overall, the ACA can be improved in terms of IPV survivor health by adding provisions specifically focused on survivors as a vulnerable, high-risk health population. As exhibited in this analysis, the ACA advanced several provisions that do aid IPV survivor health, but only within a broad sense; the specific focus on domestic and sexual violence promoted by VAWA's framework therefore becomes overshadowed in this all-encompassing health care reform bill. Beyond this, in January of 2013, the U.S. Preventative Services Task Force found sufficient evidence to recommend domestic violence screening and interventions in health settings for women of "childbearing age." However, this emphasis on women up to aged 46, coupled with a recent recognition of the prevalence of elder abuse, still fail to address IPV negative health consequences for middle-aged women (Futures Without

Violence 2015). As a result, this represents a missed opportunity under the ACA to intervene and mitigate violence for the thousands of survivors facing repeated victimization within this under-supported age range. On a similar note, both the ACA and the VAWA legislation that came before it continue to emphasize IPV as chiefly an issue of “violence against women.” While the ACA no longer refers to IPV using the narrow language of “battered women,” and includes more gender-inclusive terminology, the ACA still mandates preventive screening, and referrals to counseling, through annual well-woman visits. Future policy has the potential to be even more impactful than existing legislation by extending supports aimed at male survivors, and working to reiterate that IPV is not just a “women’s issue.”

In surveying CHCs to gain a better understanding of health center challenges, it becomes clear that high numbers of uninsured patients remain listed as the top challenge, particularly in states that did not expand Medicaid under the ACA. In addition, CHCs face difficulties in insufficient insurance reimbursement, and in workforce recruitment and retention (Paradise et al 2017). Several of these persistent impediments to comprehensive care stem from instability in CHC funding. Despite the ACA’s provisions establishing funding mandates and grants for CHCs, both the CRS and nonprofit reports emphasize the looming problem of “funding cliffs” for CHCs. Even under the ACA, CHCs receive funding only in the short-term, typically through two-year grant periods. Such funding lapses have a highly disruptive effect on essential health center operations. More permanent, long-term funding of these health centers will be a crucial step forward in ensuring stability and accessibility of services for IPV survivors, and in preventing disruption in care. To promote long-term funding, the Kaiser Family Foundation report “Community Health Centers: Growing Importance in a Changing Health Care System” recommends expanding CHC grant funding periods to a 10-year funding approach, similar to

federal funding for the Children's Health Insurance Program (CHIP). This proposed policy could stabilize the primary care system, therefore securing "a crucial dimension of access and quality" (Kaiser Family Foundation 2018). A 10-year funding strategy could additionally enable CHCs to make long-term operational decisions, including expansion of services vital to CHC survivors, without concern over whether funding would be available from one year to the next to finance such expansions. Longer-term funding therefore addresses the exact issues most detrimental to IPV survivor healthcare, and facilitates delivery of the proximate services most crucial to survivor health.

Initial reports of the first years of ACA implementation strongly support continued investment in primary care, a prevention-focused health system, and CHCs in order to meet health care needs of vulnerable patients in the U.S. (Adashi et al 649). As IPV survivors exemplify some of the most at-risk patients, with extremely high likelihood of co-occurring negative health outcomes, the ACA's emphasis on both prevention and on CHC funding is a highly effective tool towards promoting positive health for these survivors. However, both VAWA and the ACA fail to implement, fund, or fully support the exhaustive list of "comprehensive services" advocated by public health scholars, as was articulated in the Literature Review and Research Design. Alarming, the 2016 Attorney General Report on Effectiveness of Grant Programs under VAWA exposed numerous remaining areas of need to make federal funding for IPV survivor health more impactful. For example, despite the policymakers' attempt to guarantee core services for survivors under the ACA, IPV advocates identify that the ACA still falls short in sustaining these services, particularly in terms of funding, and ensuring that services are offered at both rural and urban CHCs.

Finally, future policy can complement, and enhance, ACA provisions through measures

to reduce delays in access to health care appointments, as well as through longer-term and better-defined “counseling” for survivors. Waiting for health care is detrimental for all people, as greater delays in addressing health issues may exacerbate both symptoms and long-term health issues, however, delays in care are exceptionally dangerous for survivors who may face continual abuse without intervention. Even once survivors have been removed from a situation of continued violence, the ACA mandates remain vague in defining “counseling” services available, and often only provide coverage for counseling for short periods of time. This is insufficient in addressing the complex, and often slowly emerging, mental health consequences of IPV. Thus, future policy efforts must work to both reduce health care delays under ACA health plans, and extend counseling services.

The ACA can be improved to enhance organizational capacity, and to bolster guaranteed support for treatment of co-occurring health needs. The ACA can also be amended to ensure that education and prevention strategies are modernized, and remain relevant and effective. This highlights the need for continued re-examination of existing federal health policy provisions, and crafting of more expansive, consistently funded provisions directly targeting the areas of greatest need for survivors.

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